DIVISION 56
TRAUMA PSYCHOLOGY
AMERICAN PSYCHOLOGICAL ASSOCIATION

NEWS

Honoring our past: Where we've been and where we need to go

in this issue...

COVER ART:
NISG̱A'A MOUNTAIN
BY: ROY HENRY VICKERS

Cover image features a Laxgalts'ap Community member in a mountain form with Northern Canada mountains behind her. The woman participated in a trauma workshop held by Leila Johnson, a trauma-sensitive yoga facilitator and member of Roy Henry Vickers' team. Mr. Roy's trauma-sensitive yoga art project aims to represent actual Community and promote inclusion of all body types . *This is the first time that this image has been publicly shared.*

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Honoring our past:
Where we've been and where we need to go

Unless otherwise stated, all photos are Canva Pro stock images.
Submit member cover art through *TPN*'s online submission form.

EDITORIAL NOTE

Dear *TPN* friends,

THE EDITORIAL TEAM & I WISH YOU A FRESH WELCOME to the *Trauma Psychology News* Fall 2021 issue.

As the foliage changes color in the Northern Hemisphere, we are reminded of the now-gone green leaves as well as the winter season ahead. May we honor the joy and life within each fallen leaf while acknowledging the opportunities for change that lie before us. This brings us to our first themed *TPN* issue, ***Honoring the past: Where we've been and where we need to go.***

Turning to the articles of this Fall issue, **we honor the 20th anniversary of 9/11**, acknowledging its aftermath (**p. 18**; Military & Veterans) and the lessons that have arisen (**p. 8**; Feature). **As we dive into the school year, we also shed light on cyber harassment** in academia (**p. 26**; Members), an under-recognized yet growing form of harassment given the normalcy of online, technological spaces. This issue also **reminds us of the invisibility of Asian Hate and trauma** ingrained in US history and what we can do to promote visibility (**p. 30**; Students). And of note, **as American Indian Heritage Month begins**, we must honor the ancestral lands on which we reside. With that, we are immensely humbled that world-renown artist Roy Henry Vickers has chosen *TPN* as a platform to share never-seen-before artwork from *Two Cedars,* his trauma-sensitive yoga art project aimed to increase recognition and inclusivity of Indigenous peoples and their experiences in embodied healing (**p. 22**; Multicultural & Diversity).

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 *TPN* space.

VIANN N. NGUYEN-FENG
Editor-in-Chief

Editorial Trio

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Tyson Bailey; source: TPN

PRESIDENT'S COLUMN

Tyson Bailey, PsyD, ABPP

AS 2021 BEGINS TO WIND DOWN, I have been focusing on recognizing gratitude as much as possible. Fall and winter are frequently a time of significant difficulties for those who share their stories in therapy, as there is a constant pull between what this time of the year is "supposed" to represent and the realities clients have faced, particularly when they think those experiences are their fault. The holidays and moments where spending more time stuck inside can have a profound impact on the level of distress at any age. Although clients frequently report an understanding of how important it is for me to have time away, I am also acutely aware of the impact of missing one of the most consistent relationships many clients have ever experienced. I recognize that honoring each individual's story can only be done from a place of personal connection and self-care, yet still notice the pull to adjust my boundaries each year. Talking about this openly with clients has been one of the most important ways I have navigated this over the years, which tends to bring a deeper level of connection even if through more difficult moments. I am grateful for the training that helped me to realize the power of self-disclosure within the therapeutic relationship and the continual encouragement of my support system.

In August, Division 56 completed a vote that I believe will change the course of our organization. **We have hired a consulting firm focused on diversity, equity, and inclusion to evaluate the Division's structure, activities, and governance.** Our goal is to ensure that we are identifying and challenging our blind spots and increase our understanding of the ways we are not living up to our mission. Please be on the lookout for ways that you can participate in this process if you are interested. In the meantime, you can also contact Ayli Carrero Pinedo, who is the chair of the **I-DARE task force**, to get involved. We are fortunate to have a passionate leader at the helm of this project and Ayli is going to need help from our membership in order to gather information and institute important changes.

After two successful cycles of the Division 56 **Cultivating Healing, Advocacy, Nonviolence, Growth, and Equity** (**CHANGE**) **grant**, we are thrilled to announce another round coming soon. Watch for listserv announcements and check our website's grant page for further details. This project would not have been possible without our passionate student and ECP leaders, please join me in sending thanks and congratulations to **Katy Lacefield** and **Ayli Carrero Pinedo** for their time, energy, and vision in creating this grant and helping us to support inclusive research. Further, we are excited to announce that we have committed to funding this grant continually through the **American Psychological Fund** (APF), which will begin in fall of 2022.

We will also be discussing future in-house grants with the consultant mentioned above to determine the most effective ways to provide funding opportunities for inclusive research well into the future.

The Division 56 journal ***Psychological Trauma: Theory, Research, Practice, and Policy*** continues to break all expectations that we have set. We are thankful for the leadership of **Steve Gold** (founding editor) and **Kathy Kendall-Tackett** (current editor), for creating a publication that provides an impressive array of trauma-informed scholarship. The journal has done so well that **we just authorized a permanent increase in the page numbers and two special issues** for next year. This will allow us to publish articles faster than we have in the past and meet the ever-increasing demands for our journal. We appreciate the support of our members and are grateful to the editorial team for all of their hard work.

We hope that you signed up and have logged into the **APA virtual convention** platform. The content this year is stellar as always and we are proud of the program we put together. If you haven't signed up yet, you have until November 15 to get those CEs, so don't delay! I would like to send a special thank you to **Jessica Punzo**, who put together the program while managing a move and a number of other stressors. She has been a fantastic program chair and we are all thankful she has agreed to do it again next year! Please ensure you watch for more information about the 2022 convention, which we hope will include us all being back together.

May we all commit to continued growth, risk taking, and challenging biases in 2022 and beyond.

Thank you again for choosing me as the **first**—of what I hope includes many more—**early career psychologist** President of Division 56.

Although it is not the year I imagined when I won the election in 2019, watching the scholarship and connection within this group of amazing psychologists has been inspiring. I am honored to have served as Division 56 president this year and I'm excited to see the next steps this amazing group will take in the coming years. Thank you for your support and continued commitment to advancing the field of trauma psychology.

LESSONS LEARNED FROM GROUND ZERO

TRAUMA PSYCHOLOGISTS CAN PREPARE THEMSELVES AND CLIENTS FOR FUTURE DISASTERS

A PERSONAL ACCOUNT

James Halpern

EVERYONE HAS A 9/11 STORY, where they were, who they knew, what they thought. On September 11, 2021, I led the first American Red Cross mental health team to Ground Zero looking for "walking wounded." On September 12, I began a week-long assignment managing the Missing Persons Hotline. Over the next few weeks, I escorted family members of first responders to Ground Zero as they looked over the site to see where their loved ones perished. For the next year, I supported memorials, funerals, counseled survivors, first responders, reporters, government officials, and clergy who worked at the site. Most of us who responded were shocked, confused, disoriented, vicariously traumatized, and because there was so little research and guidance, I went on to found the Institute of Disaster Mental Health at SUNY New Paltz; write, train, and present on Disaster Mental Health locally, nationally and internationally; and coauthor three textbooks on disaster mental health. I continue to serve as a Red Cross volunteer and member of the Board of Directors of the Hudson Valley Chapter, planning for and responding to COVID and other disasters.

I am sharing this personal account of my response to the 9/11 attacks, hoping that readers will better understand how to prepare themselves and their clients for disasters that are sure to come.

Some content may be disturbing to trauma and disaster survivors.

LESSON 1: OVERCOMING DENIAL TO IMPROVE PLANNING AND PREPARATION

On May 18, 2001, there was a "tabletop exercise" (i.e., a meeting for team members to discuss roles and responses during an emergency) at the American Red Cross Greater New York location in Manhattan. The response to plane crashes or any mass casualty incident, is complicated with many response organizations involved. The focus of our exercise was how our chapter would respond to an aviation incident in the New York metropolitan area. *How would we get to headquarters? Who would be our clients? How would we contact survivors?* Principle topics for the exercise were **jurisdiction, organization, and hierarchy.** There are local, state, and federal authorities as well as emergency management, police, firefighter, airline, and FBI officials and the National Transportation Safety Board. Under the Family Assistance Act of 1996, after a mass transportation incident, the Red Cross is responsible for "family care and mental health."

The scenario presented was an air traffic control tower accident at a Queens airport resulting in two passenger planes hitting a populated area in New York City, leading to hundreds of casualties. *What?!,* most of us complained to the exercise organizers, *We should be planning for a disaster that might actually happen and not some preposterous scenario.* Of course, what happened on 9/11 was far worse than this "worst case scenario." The fact that the Red Cross was planning for a low probability, high impact disaster was impressive and is important for all of our future planning. But although most of us were experienced disaster responders, we could not accept that this was even a possibility. **If we were in denial, how can we expect others in the general population to be more connected to a potential reality and to plan and prepare effectively?**

Based on my own experience of the May 2001 disaster exercise, the simplest answer to why we do not adequately prepare for disaster is **denial**. We can protect ourselves or think we are protecting ourselves if we refuse to see the threat. Denial occurs when someone is faced with a fact that is too uncomfortable to accept and so they reject it despite overwhelming evidence. Since we are surrounded by danger, and it is not helpful to be in a constant state of fear,

denial is a basic and useful defense mechanism—but only up to a point.

Denial is an obstacle to substance abuse treatment and can increase the risks of heart disease and cancer when people ignore the warning signs of disease. Denial can also keep us from being prepared for and planning for disasters.

We are more likely to deny and inadequately prepare for disasters that are not visible nor understandable (**Burmudoi & Nagai, 2017**). These factors contribute to the poor initial and continuing response to COVID-19 and our inability to take bold action on climate change. We cannot see nor understand a virus. *How can we be sure the microbial world even exists? Have you ever seen a virus under a microscope?* Climate change makes disasters bigger and badder and longer, but is neither seen itself nor easily understandable. *We don't see the greenhouse gases in the atmosphere?* People don't pay attention to threats if they lack early warning, information, skills, or knowledge (**Liu et al., 2017**). Our response to the threats of pandemic and climate change are made worse by rumor and misinformation, always present after a disaster, but made much worse with social media and extremist ideologies.

Denial keeps people from having first aid kits, N95 masks, smoke detectors, and discussing emergency plans. As trauma psychologists, we can encourage authorities to prepare for disasters through professional and local political organizations. We can help clients and their families and communities be safer at reasonable costs with effective threat assessment and mitigation without fear mongering. Some decades ago, children drowned in neighborhood pools at an alarming rate. When laws were passed mandating fences around pools, child drownings plummeted. We can help prevent disaster trauma.

We can ask our clients not only about their trauma history or toxic relationships, but also about their disaster planning. Clinical training includes understanding how to respond to trauma and disaster, but we can also help to prevent disaster trauma. Depending on where you live, you can ask clients about their disaster preparedness for heat waves, wildfires, floods, tornados, home fires, hurricanes, depending on local risk. Refer them to websites with emergency kits like the **Red Cross** or **Ready**. Trauma psychologists understand the power and danger of denial, and we can help our clients to overcome it.

LESSON 2: WEIGHING HEALTH VS. FINANCIAL COSTS

There were many more victims than the nearly 3,000 who died on 9/11. Tens of thousands of individuals worked through the recovery efforts at Ground Zero, recovering 30,000+ body parts, at extraordinary personal costs. Residents moved back to a neighborhood that was chaotic, noisy, filled with armed law enforcement and **National Guard**, sirens, and a toxic stew of chemicals, debris, and smoke. Authorities knew that the air was not safe at Ground Zero and yet reported that it was. *Why?* It is likely that a calculation was made that shutting down all of lower Manhattan including Wall Street was too costly. *Did they make the right decision? Was opening up NYC while the air was unsafe the right decision from a cost benefit analysis?* Rescue and recovery workers as well as those living close by suffered serious health consequences—and all of these workers had family and friends who were also affected. It may take decades before we know the full extent of the physical and emotional trauma to the first responders, workers, their families, residents, and others who were exposed to the toxic World Trade Center brew. The **World Trade Center Health Program** is currently treating over 100,000 with certified health conditions—20,000 with cancer. **I am one of them.** Declaring that the air was safe and opening lower Manhattan saved livelihoods but lost lives. *If the air was more or less toxic or the economics more or less impactful, would the decision have been different? Is there a sensible, ethical process to make these kinds of decisions? When would it have made the most sense to have opened lower Manhattan?* There has been no transparency about that or similar decisions.

The stark trade-off between saving lives versus livelihoods has never been more apparent than in the US response to COVID-19. The pandemic was both a financial and a public health crisis. Economic lockdowns can save thousands of lives but also create severe economic and mental health risks if businesses, factories, and schools are closed. Unfortunately, these rather complex issues have been infrequently discussed and more politicized in our current polarized environment. Counselors should be able to appreciate the importance of both lives and livelihoods and encourage rational constructive conversation and problem solving. A client asks you, *Is it safe enough for me to return to in person work, or send my child to school, or resume normal activities in this heat wave or smoke-filled neighborhood?* Let's face it, we are in the same boat as our clients (shared trauma reality), we do not have all the answers, and accurate information keeps changing. However, trauma psychologists can help their clients to process risks and rewards with calm, thoughtful conversation.

LESSON 3: THE INCREASING IMPORTANCE OF REMOTE MENTAL HEALTH AND MENTAL HEALTH CALL CENTERS

On September 12, 2001 and for over a week, I managed the **Missing Persons Hotline**, set up in the call center for NYC's public television station, **Channel 13**. People from all over the world called in to find out the status of their loved ones, many of whom were expected home but had not arrived. Hundreds of counselors made thousands of calls to frightened, anxious, and grieving relatives. At that time, it was one of the largest mental health responses to disaster. It was also the first significant disaster crisis hotline. Beginning on the evening of 9/11, the **American Red Cross Greater New York** licensed mental health volunteers managed the call center. The operation had two goals: **develop a database for missing persons and provide crisis counselin**g. After a few days, counselors received some training (e.g., *meet the client where the client is*) and debriefings at the end of shift and the end of deployments. We now know that *exit interviews* (i.e., checking in with volunteers on self-care) is recommended while debriefings are no longer best practice. The vast majority of counselors did an excellent job of providing assistance for long hours and returned to help for many days. However, some volunteers decompensated either during training, during the response, or at the end of their shifts. Some had to leave the assignment even before they started answering phones.

Since then, the **Red Cross** and other state and local agencies have organized remote mental health responses to more frequent mass shootings, killings, natural disasters, and other large-scale catastrophic events. Since 2012, the **Substance Abuse and Mental Health Services Administration** has supported a national disaster distress helpline, and communities all over the country have counselors available by phone to assist COVID survivors. **New York State r**esponded to well over 60,000 calls during COVID, mostly with clients experiencing anxiety, loneliness, and fear. Climate change will bring us an increasing number of mass casualty incidents that will necessitate remote counseling (e.g., phone, text, video). They will include events like transportation accidents, shootings, fires, floods, structural collapses, hazmat/industrial accidents, radiological events, public health emergencies, and events that we cannot even imagine. At the 9/11 call center, we received heartbreaking calls, some before there was enough time to consider the research or to consult with others on clinical wisdom.

Please consider the following actual queries to the 9/11 call center. Take a few moments and think about what you would say to a caller who asked:

- When will I know with certainty if my loved one has died?
- How could God have let my loved one die?
- Why did this happen to my loved one? My loved one was such a decent and loving family member.
- Will my family or I ever be whole again?
- Do you think that when the plane crashed (or the building collapsed) that my loved one experienced fear or pain?
- My loved one has not contacted me for days after the explosion, and I'm sure they died. However, my religious leader tells me I cannot mourn until their body is found. What should I do?
- What should I tell my children about why their parent is never coming home again?
- I am pregnant with twins but now that my spouse is dead, I don't know if I should keep them. What do you recommend?

Hint—not all, but some of these questions are more lamentations than questions. Others are survivors desperately looking for comfort or answers. I hope you agree that we need to give the helping community more training in remote disaster counseling because in the aftermath of mass casualty incidents, the point of contact between client and counselor is frequently over the phone. Communities should prepare for large-scale phone crisis counseling operations and identify adequate facilities with plans and protocols for staff counseling supervisors and managers as well as to train phone crisis counselors.

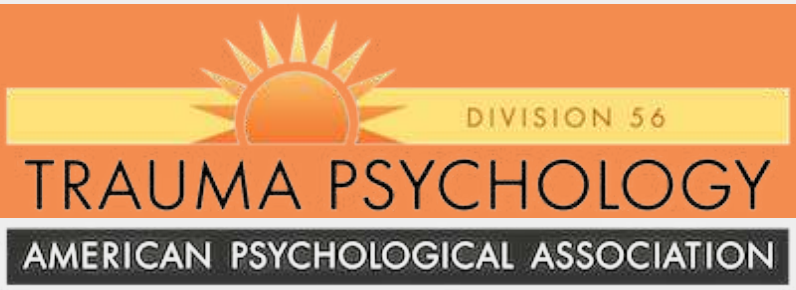
It is not alarmist to state that there are disasters and catastrophes coming our way. We can help our clients to prepare as well as engage in conversations with them about navigating health and financial risks even when we do not have answers or all the accurate information. We can prepare ourselves to respond to the increasing number of mass casualty incidents in our future by getting disaster mental health training for both in-person and remote counseling.

James Halpern; submitted photo

JAMES HALPERN is Professor Emeritus and Founding Director of the Institute for Disaster Mental Health at SUNY New Paltz. He has received numerous grants to develop curriculum and provide training in disaster mental health throughout the US and abroad. Dr. Halpern has co-written three disaster mental health textbooks, has consulted for the United Nations on assisting victims of terror, and developed training modules for United Nations Emergency Preparedness & Support Teams and mission leaders. He has provided direct service to disaster survivors and served in a leadership role at large-scale national and local disasters (e.g., 9/11, Flight 587, Florida Hurricanes, Hurricane Katrina, Newtown School shooting, explosions, fires, floods, COVID-19).

A brief and earlier version of this article may be found on *Psychology Today*.

Citation: Halpern, J. (2021). Trauma psychologists can prepare themselves and clients for future disasters: Lessons learned from ground zero. *Trauma Psychology News, 16*(3), 8-12. https://traumapsychnews.com



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

OYENIKE BALOGUN-MWANGI

WHO'S WHO

Oyenike Balogun-Mwangi; submitted photo

OYENIKE BALOGUN-MWANGI

she/her

Assistant Professor, Salve Regina University
Editorial Fellow, *Psychological Trauma*

PhD, Counseling Psychology, Northeastern University

Areas of interest and expertise

Mental health disparities, cross-cultural issues in mental health, body image among African women

Hobbies

Running, hiking, cooking, crocheting

WHAT LED YOU TO THIS FIELD AND CAREER PATH?

While I was not at all considering psychology as a career path, I made the switch after taking an introductory psychology elective as a senior in high school. I was transfixed by one assignment in particular—applying psychological theories/concepts to characters in the film *Ordinary People*. This one class changed my trajectory, and I haven't looked back.

WHAT'S SOMETHING INTERESTING THAT YOU LEARNED IN THE FIELD?

I think I came into the field of counseling psychology believing that I would gather tools to be a **changemaker** for others who were seeking to improve their lives. I have been so grateful to discover that the individuals with whom I work are also agents of my transformation and growth.

WHAT ADVICE WOULD YOU GIVE TO SOMEONE NEW IN YOUR FIELD?

Find supportive mentors who in their clinical practice, teaching, and/or research move you and inspire you. I have found mine in **Dr. Tracy Robinson-Wood**, who has been steadfast in her support and encouragement.

> **STARTING OUT IN THE FIELD CAN COME WITH UNEXPECTED CHALLENGES. YOU WILL NEED A SOLID BENCH OF MENTORS WHO KNOW YOU AND WHO YOU TRUST TO GIVE YOU PRACTICAL DIRECTION AND WARM SUPPORT.**

APA INTERNATIONAL STIPEND AWARDEES

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

AS THE 2021 AMERICAN PSYCHOLOGICAL ASSOCIATION CONVENTION was virtual this year and travel did not take place, it was recognized that support for international students from developing countries, engaged in trauma-related research and activities was important to continue, especially given the challenges occurring as a result of the pandemic. Therefore, it was decided to award the travel stipend for virtual presentations at the 2021 APA Convention to help support students from developing countries.

Division 56 has been providing an annual travel stipend of **$1,000** for international students who are citizens of developing countries to attend the APA Convention. The annual stipend is a project of the **International Committee** with a subcommittee determining the recipient(s) who is enrolled in a graduate psychology program and has a trauma-related poster or paper accepted or is a participant in a panel/symposium at the convention.

KEEP IN MIND

For those organizing sessions with international students from developing countries, consider submitting for the 2022 APA Convention Travel Stipend.

THE TWO RECIPIENTS OF THE 2021 AWARDS WERE:

Janet Surum, a citizen of Kenya, and
Rita Rivera, a citizen of Honduras.


Janet Surum; submitted photo

JANET SURUM is enrolled in a **PhD** program in **Educational Psychology**, at **Moi University, Kenya**. Her APA presentation was part of a symposium and was entitled *Personal and Socio-Contextual Factors as Predictors of Academic Resilience in Trauma-Exposed Public Secondary Schools Students in Turkana County, Kenya.* In addition to her studies, Janet is also part-time lecturer at **Mount Kenya University**, teaching several psychology-related courses. Previously, she worked at a secondary school identifying pupils who required psychosocial and counseling support, providing training to staff on basic counseling skills, and also serving as head of the guidance and counseling department at a secondary school at a longstanding large refugee camp in Kenya.

RITA RIVERA is enrolled in a **PsyD** program in **Clinical Psychology** at **Albizu University** in Miami, Florida. Her presentation was entitled *Prolonged Grief Disorder (PGD) following the COVID-19 Pandemic* as part of a symposium on trauma, grief, and resilience in response to COVID-19. In addition to her studies, Rita has worked as a research assistant at **Albizu University**. She also works at a health network in Florida providing individual, family, and group therapy in **English and Spanish** for adolescents in an inpatient psychiatric program. Further, Rita conducts cognitive status assessments and administers inventory scales to assess emotional and behavioral symptomatology in an inpatient healthcare system.


Rita Rivera; submitted photo

A thank you to **Jyothi Vayalakkara**, **Chrysalis Wright**, and **Laura Captari**, who served as the selection subcommittee of the International Committee to determine the recipients.

THE AFTERMATH OF 9/11 FOR FAMILIES OF VETERANS WITH TRAUMATIC BRAIN INJURY

Charles Edmund Degeneffe
Section Editor: Emre Umucu

SEPTEMBER 11, 2021 MARKS THE 20TH ANNIVERSARY of acts of terrorism against the United States at the World Trade Center, the Pentagon, and the fields of Shanksville, Pennsylvania. In response, the United States and its allies engaged in the **Global War on Terrorism**, with military operations focused on **Afghanistan** (Enduring Freedom, Freedom Sentinel) and **Iraq** (Iraqi Freedom, New Dawn, Inherent Resolve). Across these operations, as of September 6, 2021, a total of **7,053** US service members have been killed in action (**US Department of Defense, 2021**). With the departure of the last remaining troops from the **Hamid Karzai** International Airport on **August 30, 2021**, all military operations in Afghanistan ended.

Going forward, the United States will no longer maintain a major military presence in Iraq and Afghanistan. However, what remains is the significant number of military personnel who will continue to face the cost of their service with lifelong combat-related traumatic brain injuries (**TBI**) and associated polytrauma injuries due to improvised explosive devices and other blast generating weapons. At the height of combat operations, from 2001 to 2015, approximately **2.5 million** US military personnel were deployed to both countries (**Sim et al., 2015**), with an estimated **15% to 20%** incurring mild TBI (**Baldassarre et al., 2015**). According to the **Defense Medical Surveillance System** (**2021**), from 2000 to the first quarter of 2021, there were **439,609** medically diagnosed TBIs among all military personnel worldwide. Because TBI is so common, it carries a moniker as *the signature injury* of military operations in Iraq and Afghanistan (**Lindquist et al., 2017**).

TBI incurred during military service in combat differs from civilian-incurred injuries by the overlay of posttraumatic stress disorder (**PTSD**) and other polytrauma injuries. Because of dramatic improvements in battlefield medicine, many who would have died in previous conflicts now survive (**Degeneffe et al., 2015**), but often with lifelong disabilities. Improvised explosive devices and other explosive devices result in an array of primary, secondary, tertiary, and quaternary impacts that cause TBI and polytrauma

injuries because of simultaneous damage to multiple body systems (**Burke et al., 2009**). While both diagnoses can occur independently, TBI creates a higher risk for PTSD when injury to the brain reduces the capacity to respond effectively to the chronically high-stress environment of combat. Veterans with TBI and PTSD face the stigma of asking for help while encountering challenges with reintegrating with family and other areas of civilian life (**Burke et al., 2009**).

Like the civilian population, veterans with TBI returning home from service in Iraq and Afghanistan frequently rely on family to meet their needs for care and support. While most TBIs among military service members are mild forms of injury (**Defense Medical Surveillance System, 2021**), others present moderate to severe levels of impairment. In their seminal study on family caregiving for service members with TBI and polytrauma injuries discharged between 2001 to 2009 from a **US Department of Defense/ Department of Veterans Affairs (VA) Polytrauma Rehabilitation Center**, **Griffin et al. (2012)** referred to family involvement as the *invisible side of war* and documented the many hidden costs of caregiving. Among 564 family caregivers:

- approximately **60%** of participants were the only persons providing care;
- after a median 4 years post-injury, **22%** of the family members with TBI relied on family for help with activities of daily living;
- among this latter group, **49%** of family members provided **80 or more hours** of care weekly;
- women (**79%**) faced the brunt of family care responsibilities (like in the civilian population);
- **62%** of participants were parents;
- **32%** were spouses, in terms of family member type.

The available research documents the high cost of providing this care with elevated burden (**Brickell et al., 2019**) and depression (**Moriarty et al., 2018**), and compromised quality of life (**Carlozzi et al., 2016**).

In 2005, the US Department of Defense and the VA, recognizing America's responsibility to better understand and address the needs of veterans with TBI, jointly established the **Polytrauma System of Care**, a nationwide network of inpatient rehabilitation hospitals (in **Richmond**, Virginia; **Minneapolis**, Minnesota; **Tampa**, Florida; **Palo Alto**, California; and **San Antonia**, Texas), regionally based outpatient clinics, and mechanisms to link veterans to local services (**Degeneffe et al., 2015**). The **VA (2021)** maintains extensive research initiatives to better understand and respond to veteran TBI through efforts such as the TBI Model Systems, the Translational Research Center for TBI and Stress Disorders, the Brain Rehabilitation Research Center, the War-Related Illness and Injury Study Center, and the Defense and Veterans Brain Injury Center.

The federal government's efforts on veteran TBI are applauded. What is missing, however, is sufficient understanding of the needs, experiences, and intervention strategies to better assist their family caregivers. A systematic review (**Shepherd-Banigan et al., 2018**) on intervention studies for family caregivers of veterans with TBI, PTSD, or polytrauma, located few studies directed to families of veterans with TBI, the **Veterans' In-Home Program**. Psychologists and other rehabilitation professionals have neglected specific focus on family caregivers. After 20 years of engagement in the **Global War on Terrorism**, the term *invisible side of war* unfortunately still applies.

HELP IS AVAILABLE. The **VA Caregiver Support Program** (**2020**) provides information, suggestions, and links to find resources and support. The **Caregivers and Veterans Omnibus Health Services Act of 2010** (Brain Injury Association of America [**BIAA**], **2021**) provides caregivers of post-September 11, 2001 Veterans with a line of duty disability financial support, health care, respite, care-related travel, and mental health services. The **BIAA** maintains national and local resources to assist family members with support groups and information. However, more needs to be done. Psychologists and other professionals that work with families of veterans with TBI are called to engage in research, program development, and outreach to meet the needs of this largely silent population in the United States and countries worldwide.


Charles Edmund Degeneffe; submitted photo

CHARLES EDMUND DEGENEFFE, PhD, MSSW, CRC, is a Professor in the San Diego State University (SDSU), Rehabilitation Counseling Program, and Chair of the Department of Administration, Rehabilitation, and Postsecondary Education. He also coordinates the SDSU Cognitive Disabilities Certificate Program. Dr. Degeneffe serves on the San Diego Brain Injury Foundation Board of Directors and is a member of the California Traumatic Brain Injury Advisory Board. Dr. Degeneffe's primary research interests focus on family caregiving and adjustment following acquired brain injury.

Author Note

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

BEHIND THE COVER ART

AND THE EMERGENCE OF *TWO CEDARS*

Leila Johnson & Roy Henry Vickers
Section Editor: Claire J. Starrs

The Fall 2021 cover image of *Trauma Psychology News* features Roy Henry Vickers' *Nisga'a Mountain,* artwork of a Laxgalts'ap Community member in a mountain form with Northern Canada mountains behind her. The woman participated in a trauma workshop held by Leila Johnson.

This is the first time that this image has been publicly shared.

HOW CAN MOVEMENT HELP HEAL intergenerational trauma or traumatic stress? When we are free to make choices based on how we feel in the present moment, we help heal the mind-body experience. Therefore, two of the most powerful questions we can ask ourselves in a trauma-informed practice are:

1. What am I noticing in my body?
2. What do I want to do about that?

Here begins the story of *Two Cedars,* Roy Henry Vickers' trauma-sensitive yoga art project aiming to represent actual Community and promote inclusion of all body types.

LAND ACKNOWLEDGEMENT

First, we recognize the longterm impact of colonial rule, the cultural genocide and oppression that took place on these Unceded Homelands, and the pervasiveness of structural racism. The violence towards Indigenous Peoples continues when treaties are broken, waters are polluted, and stories are silenced.

We are committed to the actions and values rooted in anti-oppression and universal trauma-informed care. We pay respect to the Sages and the Elders who came before us, and to all First Nations, Inuit, Métis, and Indigenous Peoples globally who have continuously cared for these Lands which now care for all of us.

WHY DO WE ACKNOWLEDGE THE LAND?

Acknowledging the Land is an ongoing, mindfulness practice and an Indigenous protocol. On September 13, 2007, the **United Nations General Assembly** adopted a universal framework entitled **United Nations Declaration on the Rights of Indigenous Peoples** (**UNDRIP**) after many years of consultation with communities worldwide. These guiding principles acknowledge that *"indigenous peoples have the right to the lands, territories, and resources which they have traditionally owned, occupied, or otherwise used or acquired"* (Article 26), and states these rights *"recognized herein constitute the minimum standards for the survival, dignity, and well-being of the indigenous peoples of the world."* (Article 43)

We recognize the Land as a way of not just honoring Indigenous rights but also expressing our gratitude to those whose Territories we are connected to—a small but important step in understanding and remaining in right relations.

THE EMERGENCE OF *TWO CEDARS*

Two Cedars (*see p. 24 for artwork*) emerged from conversations with the artist **Roy Henry Vickers** and Community and from the shared goal of impact through partnership. We explored needs, building cultural bridges, and how to offer trauma-sensitive yoga in an environment where culture is first. We were motivated from asking, *if cultural genocide is part of the trauma, could culture representation be the healing?*

The image brings together two ancient pathways and signifies intuition, experience, science, and representation as imagined by the artist. It is an invitation to notice, also known as **interoception**, and an invitation to make choices about your body based on your present moment experience.

The design of the poster was influenced by the importance of cultural contextualization within a trauma-informed initiative and by the concept, **two-eyed seeing**,* a framework introduced by **Elders Albert and Murdena Marshall** from the **Moose Clan** of the **Mi'kmaw Eskasoni Nation**; a term also known as ***Etuaptmumk***, the **Mi'kmaq** word for "*the gift of multiple perspectives.*" (**Roher, et al., 2021**) This concept is centered on being a participatory health approach, rooted in decolonization and self-determination, and likened to learning to see from one eye the strength and wisdom of Indigenous ways of being** and learning to see from the other eye the options in Western research. In learning to use both eyes together, a co-learning with all of our understanding, it is possible for us to have a shared responsibility for the greater good and future generations.

As cited in the **2012 Report of the Truth and Reconciliation Commission of Canada**, developing more culturally appropriate curricula is an accountable call to action [section 10 (iii)], not just for governments but also for non-profit organizations working toward **"right relations"** with Community. Actively engaging in "right relations" and the use of more cultural contextualization may also help remove the barriers that are often associated with accessing mental health support.

The *Two Cedars* artwork is now a part of a larger project and vision to help explore further awareness and to help promote more creative approaches that combine evidence- and culture-based medicines.

Notes

⁎ "Two-Eyed Seeing was included in the five-year strategic plan released by the Canadian Institutes of Health Research's (CIHR) Institute for Aboriginal People's Health, informing funding opportunities and the overall vision for the future of Indigenous [11, 12]. In 2017, it also featured in the Naylor report, the Canadian government's fundamental science review [13]." (Roher, et al., 2021)

⁎⁎ It should be emphasized that one set of understandings may not be representative to all Aboriginal or Indigenous perspectives, but rather one view in a multitude of Aboriginal and Indigenous views.

LEILA JOHNSON is the co-founder of We The Mindful, a 501(c)3 and registered Canadian non-profit that aims to transform colonial impact through collaboration with local marginalized communities, supporting community-led initiatives in the advancement of cultures with trauma-informed care. Leila has been working as a yoga educator, social entrepreneur, and wellness advocate since 2004 with a focus on women's mental health, pre/postnatal care, and women and children affected by war or those fleeing conflict and oppression. Selected work experience includes helping to implement a movement and mindfulness program for a detention center in Addis Ababa, Ethiopia; working with former child soldiers in Colombia under the the Nobel Peace Prize Nominee, Father Gabriel Majia; and offering movement, somatic play, and imagination work for children at a United Nations Refugee Camp near the Lebanon-Syria border. Leila is a founding member of the editorial board for *Voices Against Torture: International Journal on Human Rights*, a semi-annual peer-review publication.

Leila Johnson; photo from Trauma Center Trauma-Sesnsitive Yoga

Roy Henry Vickers; photo from artist's website

Citation: Johnson, L., & Vickers, R. H. (2021). The emergence of two cedars. *Trauma Psychology News, 16*(3), 22-25. https://traumapsychnews.com

ROY HENRY VICKERS is a Grammy Award nominated artist, storyteller, traditional carver, and publisher and author of several award-winning books. In addition, he is a recognized leader in the First Nations community, and a tireless spokesperson for recovery from addictions, trauma, and abuse.

Mr. Roy is also known around the world for his limited edition prints. His work has been the official gift of the Province of British Columbia to visiting foreign leaders. In 1987, his original painting *A Meeting of Chiefs* was gifted to Her Majesty Queen Elizabeth II, and in 1993, his prints *The Homecoming* were the Province's gift to Bill Clinton and Boris Yeltsin. Recently, he collaborated with the Grateful Dead on their *Pacific Northwest* boxed set, earning a Grammy Award nomination.

More information, art, and stories can found at the Roy Henry Vickers Gallery in Tofino, British Columbia or online: https://royhenryvickers.com/

CYBER HARASSMENT IN THE ACADEMY

Heather Littleton
& Amie Grills

UNFORTUNATELY, BEING THE TARGET OF CYBER HARASSMENT is an extremely common experience among academics, particularly among those who are members of marginalized and minoritized groups. As trauma researchers and clinicians, we are uniquely situated to advocate for better protections and support for those targeted by cyber harassment within the academy. We hope that by highlighting this issue and sharing our own experiences with cyber harassment, we can help destigmatize this experience and increase awareness regarding the potential long-term impacts of these experiences.

Our experiences with cyber harassment have been ongoing for over a decade. It began early in our careers, compounding the typical worries of negative evaluation for early career academics. It also presented a constant stress to clear our names for professional and personal reasons. My (***Heather***) cyber harassment began in 2009 when negative reviews of my teaching began appearing on online professor rating platforms. At first, the harassment was an annoyance with new reviews appearing every few months, filled with harsh and critical commentary regarding my teaching ability, personal mannerisms, and commitment to serving students. I reassured myself that this harasser would surely stop at some point. However, as time passed, the reviews became more vitriolic and frequent instead. Among other accusations, the harasser alleged that I engaged in racial discrimination in the classroom, that I referred to students using racial slurs, that I was engaging in sex with students in my office, and that I plagiarized others' work. The reviews were posted across a growing number of online platforms including professor rating sites and healthcare provider rating sites (my harasser was able to set up profiles of me on these sites even though I did not have a private practice). I also became aware that similar reviews were being posted about several colleagues (although far less frequently). As a result, I reached out to my colleague (***Amie***) and made her aware that there were similar false statements being made about her on professor rating platforms, with the comments and language aligning closely. The reviews were often written in a rambling, disjointed and often nearly incoherent style, and included repeated mentions of our full names.

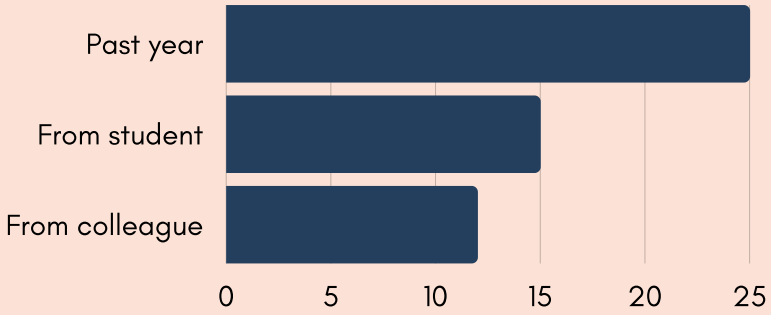
As the harassment became more frequent and vitriolic, we began engaging in a largely unsuccessful campaign to try to stop it by contacting the online platforms that enabled it. Although some sites would remove the more offensive and defamatory reviews, almost none would remove our names from the site; this was true even in cases where the site was listing reviews in reference to courses taught at universities where we were not currently employed. Ultimately, any reviews removed would be replaced with new ones several times per year.

As is often the case among targets of cyber harassment, it was difficult to get assistance in ending the online harassment we experienced. The sites would not provide any information about who was posting the reviews, such as an IP address or approximate geographic location that would allow us to pursue action against the offender. Even when presented with compelling evidence that the reviews were false and part of a multi-year long campaign of cyber harassment, some sites would state they were within their legal rights to post reviews known to be false. Ultimately, after multiple attempts to seek guidance and help from various university offices, I (***Heather***) was able to secure assistance from the university attorney's office who wrote a cease-and-desist letter to one online site arguing that the reviews were negatively affecting the university's reputation; the site removed my name from their platform within **24 hours** of receiving the letter.

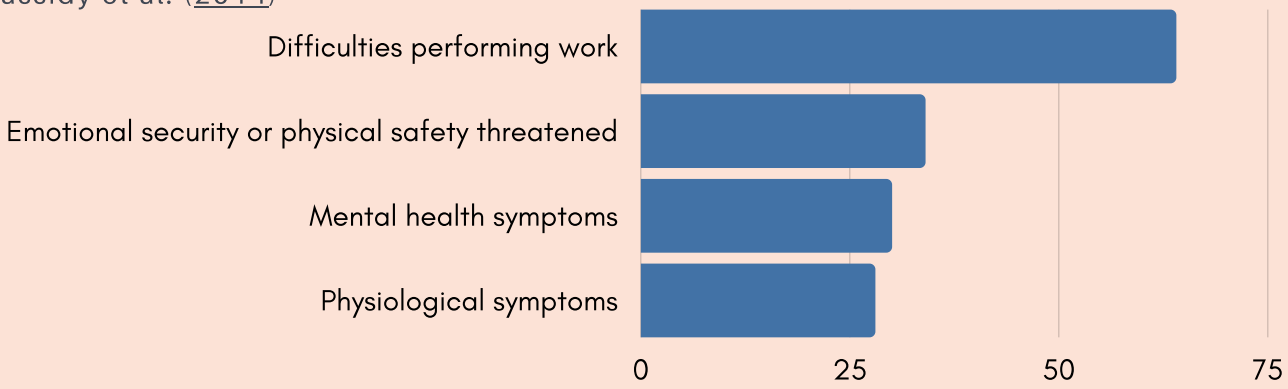
In 2015, over **six years** after it began, the cyber harassment took a new turn for me (*Heather*), when my harasser tracked down my personal cell phone number. She began calling me, screaming vulgarities at me if I answered the call. When I stopped answering, she began repeatedly calling up to **20 times an hour**, using a new number each time so I could not block the calls. I contacted the local police about this telephone harassment, and they informed me there was nothing they could do as she was using Google Voice numbers, which they could not trace. I had no choice but to change my phone number. My harasser continues to regularly post false and defamatory online reviews of me, over **12 years** after she began, and we remain unable to take action as the harasser utilizes technology to protect her anonymity.

Although the exact nature of our experiences of cyber harassment may be unique, research supports that individuals in academia are frequently victims of cyber harassment. For example, a survey of over **300** faculty and teaching instructors found that **25%** had experienced cyber harassment in the past year, with **15%** reporting experiencing harassment from a student and **12%** from a colleague (**Cassidy et al., 2016**). Targets of cyber harassment described it as having an overwhelmingly negative impact on them, including stating that it led to difficulties performing their work (64%), feelings that their emotional security or physical safety was threatened (34%), and the development of mental health (e.g., depression, anxiety; **30%**) or physiological (e.g., headaches, nausea; **28%**) symptoms. Of note, although over two-thirds of the targets of cyber harassment tried to do something to stop it, fewer than half were successful in doing so. The majority of targets also believed that their university did not have clear, effective, and/or enforced policies to respond to cyber harassment (**Cassidy et al., 2014**).

Percentage of survey respondents who reported experiencing cyber harassment
N = 300; Cassidy et al. (2016)



Percentage of participants reporting negative impacts of cyber harassment
Cassidy et al. (2014)



In addition to cyber harassment from within the academy, individuals who conduct research on controversial topics, particularly those who engage in public scholarship, may find themselves the target of extensive and organized cyber harassment campaigns, with the harassers engaging in multiple tactics including *"doxing"* and making threats of violence (**Frangou, 2019; Kavanaugh & Brown, 2020**). At the same time, many academics feel increasing pressure to engage with their scholarship in online public forums (**Kavanaugh & Brown, 2020**). Scholars who become the targets of these cyber harassment campaigns often find themselves trying to manage it on their own, without institutional support (**Frangou, 2019**). Further, members of groups who have been traditionally marginalized in academia and society at large, including women, sexual and gender minorities, and racial/ethnic minorities, are particularly vulnerable to becoming targets of these types of cyber harassment campaigns (**Kavanaugh & Brown, 2020**).

Given the frequency of cyber harassment in academia, it is critical that universities provide the necessary support to faculty and staff who experience harassment. This includes having clear anti-harassment policies which are inclusive of cyber harassment. All faculty and staff should receive training regarding what encompasses cyber harassment and the procedures for reporting it. Similarly, student conduct policies should be inclusive of cyber harassment, including contra power harassment, defined as harassment perpetrated by individuals with less power against those with more power, such as harassment of faculty by students (**Cassidy et al., 2014**). Universities should also have clearly delineated procedures for reporting and investigating allegations of cyber harassment in a timely manner.

Universities also need to provide strong support to faculty who are targets of cyber harassment by individuals or groups outside of the university. This includes having a detailed communication plan in place to respond to cyber harassment, as well as employing individuals with the requisite expertise to provide technical support to employees experiencing harassment. In addition, faculty who experience cyber harassment should be provided additional protections (e.g., email filters, additional campus security, cease and desist letters to platforms that host the harassment; **Marwick et al., 2016**). University administrators should also support faculty members' decision not to engage in certain forms of public scholarship that could open them up to cyber harassment. Faculty who engage in public scholarship, particularly those who are members of marginalized groups or who conduct research on controversial topics, should also receive assistance from their university in how to reduce their risk of cyber harassment. Finally, universities should recognize the harms of cyber harassment and provide support services (e.g., counseling, legal consultation) to faculty who experience it.

As trauma psychologists, we can be actively involved in advocating for and working with our institutions in developing strong policies and procedures surrounding cyber harassment. Further, we can be available to provide support to targets of harassment, either informally or formally, including by validating the very real harms of cyber harassment. Likewise, we can educate administrators at our institutions regarding the harms of cyber harassment and the importance of ensuring that targets are protected from damage to their careers and reputation as a result. Finally, we can advocate for strong laws which make it easier to prosecute cyber harassers, as well as laws that hold organizations accountable that enable cyber harassment to occur on their platforms.

HEATHER LITTLETON, PhD, is the Director of Research Operations and Associate Professor at the Lyda Hill Institute for Human Resilience at the University of Colorado Colorado Springs. Her work focuses on social-cognitive and ecological factors in trauma recovery as well as the use of technology to deliver efficacious trauma prevention and intervention programming. Although her work has focused on the experiences of survivors of a number of different types of trauma, the majority of her research focuses on the experiences of sexual assault survivors.

AMIE E. GRILLS, PhD, is a Professor of Counseling Psychology and Applied Human Development at Boston University. She is a licensed clinical psychologist and researcher, whose work specializes in anxiety, trauma, depression, and behavioral difficulties (particularly in children), as well as the development and evaluation of cognitive-behavioral assessments and interventions, including those conducted using web-based designs.

Citation: Littleton, H., & Grills, A. E. (2021). Cyber harassment in the academy. *Trauma Psychology News, 16*(3), 26-29. https://traumapsychnews.com

Heather Littleton; submitted photo

Amie E. Grills; submitted photo

ADDRESSING TRAUMA IN ASIAN AMERICANS

A CALL TO ACTION FOR DISSEMINATION & IMPLEMENTATION SCIENCE

Wendy Chu &
Andrea Chi Ern Ng
Section Editors:
Jack Lennon &
Emily Rooney

ASIAN AMERICANS ARE THE MOST DIVERSE and fastest growing ethnic group in the United States (**Sue et al., 2021**). However, issues affecting Asian Americans remain invisible due to cultural phenomena such as the **model minority myth** that assumes Asian Americans are universally high-achieving and successful (**Yip et al., 2021**). This has consequently diverted attention from the mental health needs of Asian Americans. Anti-Asian racism increased drastically during the COVID-19 pandemic as **Stop AAPI Hate** (**2021**) found a **153% increase** in hate incident reports from **March 2020 to March 2021**. This spur in racial violence further exacerbates existing mental health disparities (**Wu et al., 2021**). Thus, it is both crucial and timely to advance our ability to address and understand trauma in Asian Americans.

This article contextualizes trauma in Asian Americans, reviews evidence-based treatment for trauma, and discusses barriers to mental health care. Further, it describes how dissemination and implementation science can address the burgeoning mental health needs of trauma-exposed Asian Americans and concludes with future implications. Of note, we use the term Asian American to include any individual of Asian descent living in the United States. While this umbrella term overshadows many within group differences, we assert that shared experiences of racial marginalization define the group (**Sue et al., 2021; Yip et al., 2021**).

TRAUMA IN ASIAN AMERICAN COMMUNITIES

Trauma, such as refugee trauma, sexual assault, and racial discrimination, is common in Asian American communities. Specifically in **Southeast Asian refugees**, trauma from mass political violence is pervasive and has long-term health consequences (**Wagner et al., 2013**). Asian American survivors of sexual assault have more negative beliefs about themselves (e.g., *"I am inadequate"*) and self-blaming cognitions than their White counterparts, which predicts greater severity of posttraumatic stress disorder (PTSD; **Koo et al., 2014**). Other factors such as immigration and acculturation stressors, and the recent rise of anti-Asian violence, have also been associated with poor mental health outcomes and increased rates of racial trauma in Asian Americans (**Li, 2016; Wu et al., 2021**). The complexity of trauma in Asian Americans due to cultural factors also warrant treatment considerations.

EVIDENCE-BASED TREATMENT FOR TRAUMA

Alarmingly, few studies have tested the effectiveness of available evidence-based treatments in Asian Americans. Indeed, only five randomized trials have evaluated PTSD treatment in Asian American adult samples, yet none have included youth samples (**Huey Jr. & Tilley, 2018; Pina et al., 2019**). Although limited in number, these studies demonstrated that:

- **culturally-adapted cognitive behavioral therapy** is effective at improving PTSD symptoms with Southeast Asian immigrants;
- **mindfulness-based interventions** have also been discussed as possible trauma interventions among Asian American populations (**Chu & Sue, 2011**).

However, substantial research is still needed to determine whether extant trauma treatments are efficacious in Asian American populations, particularly in youth.

BARRIERS TO MENTAL HEALTH CARE

Asian Americans encounter individual and structural barriers to accessing evidence-based mental health care.

A common **individual-level barrier** is a high stigma towards professional help-seeking, as Asian Americans are the least likely to seek any mental health services among any racial group (**Cook et al., 2017**).

Structural barriers such as:

- low knowledge on accessing services,
- low availability of linguistically appropriate services, and
- high service costs

are even greater threats to accessibility (**Kung, 2004**).

Moreover, there is a lack of training to equip clinicians with skills to address issues related to race, such as discrimination (**Chu et al., 2021**). Indeed, actions to reduce barriers and increase access to effective mental health care for Asian Americans are necessary.

DISSEMINATION AND IMPLEMENTATION (DI) SCIENCE

DI science as a field is particularly well-positioned to lead such efforts for the Asian American community. Dissemination research is the study of how information is distributed, while implementation research is the study of the adoption and integration of such information into contexts (**Glasgow et al., 2012**). Though DI science in mental health has traditionally examined how evidence-based treatments are integrated into routine care, recent scholars have urged the field to take a more ecological approach by aligning evidence-based practices with setting- and person-specific factors of culturally underserved communities. For instance, **Atkins et al. (2016)** described a four-step process that leverages an ecological-public health framework. This process outlines the:

1. selection of a setting important to the target population,
2. identification of goals for the setting and the mental health benefits for the population,
3. identification of key opinion leaders to identify and promote activities and intervention strategies that support the goals, and
4. identification of resources to implement and sustain activities and strategies.

DI scientists can also integrate **anti-racist theories** (e.g., critical race theory), **measures** (e.g., qualitative methods), and **approaches** (e.g., community-based participatory research) into frameworks to promote mental health (**Shelton et al., 2021**). As such, we highlight one example of how a trauma-informed intervention was implemented to serve American Indian youth.

DI CASE EXAMPLE

American Indian youth are **2.5 times** more likely to experience trauma than White youth, contributing to higher risks of PTSD (**Indian Health Service, 2003**). To target this risk, **Goodkind et al. (2010)** implemented a trauma-informed intervention on American Indian land by selecting school-based health centers as the context, as schools, especially in rural areas, are the most accessible service setting for American Indian youth. They identified goals by meeting with key opinion leaders such as tribal leaders, school board members, and service providers, who prioritized addressing trauma in their community's youth. **Cognitive Behavioral Intervention for Trauma in Schools (CBITS)** was selected as the intervention given preliminary findings demonstrating its effectiveness in American Indian populations (**Morsette et al., 2009**). The research team collaborated with their community partners to adapt CBITS to better fit the school context and youth population, including a culturally-sensitive interview and screening process, and group and individual sessions with youth, parents, and teachers.

Results found significant improvements of PTSD, anxiety, and avoidant coping symptoms. Importantly, the researchers described steps to further increase the effectiveness and sustainability of the intervention, such as the use of booster sessions, individual or community intervention strategies, and less resource-intensive screening procedures. The researchers demonstrated **cultural humility and sensitivity** to the community's needs throughout the implementation process and created an equitable collaboration, which enabled meaningful impacts on the needs of American Indian youth. **Given the effectiveness of DI efforts as illustrated by this example, similar efforts addressing trauma in Asian Americans should be considered.**

IMPLICATIONS FOR RESEARCH, PRACTICE, & POLICY

To make strides in supporting Asian Americans who have experienced trauma, several implications and next steps for research, practice, and policy are discussed.

Research

Currently, only **0.17%** of the total budget for the **National Institutes of Health** funds research on Asian Americans (**Doàn et al., 2019**), which calls for a higher allocation of funds towards Asian American research. Increased representation in clinical trials is also needed to understand the effectiveness of trauma interventions in Asian Americans. The experiences of Asian Americans are also poorly understood, especially in contemporary times of rising anti-Asian violence. As such, research should elucidate on how racial trauma impacts Asian American communities to identify strategies to best promote their wellbeing.

Practice

Clinicians should practice cultural humility in inquiring how structural forces contribute to experiences of trauma for Asian American clients. Training to acquire skills to facilitate such discussions may be needed as one systematic review found that discrimination is infrequently discussed in cultural competence trainings for mental health providers (**Chu et al., 2021**). Furthermore, clinicians should collaborate with their clients to explore cultural values and beliefs to identify culturally-relevant activities that may facilitate healing and resistance. In line with DI practices, clinicians should select and tailor mental health treatments to best meet the setting context and specific needs of Asian Americans (**Huey Jr. & Tilley, 2018**).

Policy

Local, state, and federal systems should mandate data disaggregation in Asian American populations as disparities exist among ethnic groups (**Shimkhada et al., 2021**). Policies should fiscally fund the implementation of trauma care in community and school settings where many Asian Americans are located. Additionally, policymakers should actively collaborate with DI scholars working with Asian American communities and leaders through initiatives such as the **Research-to-Policy Collaboration** to guide evidence-based policymaking that serves Asian Americans.

CONCLUDING REMARKS

In sum, there is a critical need to advance research, practice, and policy to improve the wellbeing of Asian Americans affected by trauma, especially given the current sociopolitical context. We urge DI science, trauma psychology, and other fields to take upon these implications to address the shortcomings of the historical injustices against Asian Americans and build a future where Asian American communities affected by trauma have equitable opportunities to thrive.

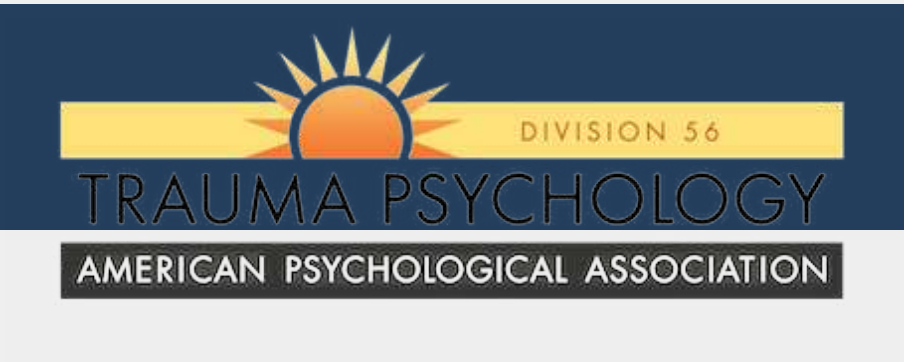
Wendy Chu; submitted photo

Andrea Chi Ern Ng; submitted photo

WENDY CHU, BA, is a Chinese American, third-year doctoral student in Clinical-Community Psychology at the University of South Carolina. Her research centers around improving the cultural competency of community and school mental health services for underserved youth and families. Specifically, she examines the dissemination and implementation of evidence-based practices to better engage and address the mental health needs of disadvantaged populations such as racially marginalized youth and low-income families. Clinically, Wendy has experience delivering evidence-based treatments to youth and families affected by trauma at a nonprofit children's advocacy center and community mental health agency.

ANDREA CHI ERN NG, BA, is a second-year doctoral student in the Clinical Studies Program at the University of Hawai'i, at Mānoa and was born and raised in Malaysia. Her research interests lie in examining how evidence-based treatments are implemented within public mental health contexts across communities, schools, and states. Specifically, she is interested in adapting treatments to not only function optimally in certain settings, but also to better help families and communities of diverse cultural backgrounds. In addition, she enjoys mentoring and providing resources to traditionally underserved undergraduate students such as transfer and international students.

Citation: Chu, W., & Chi Ern Ng, A. (2021). Addressing trauma in Asian Americans: A call to action for dissemination and implementation science. *Trauma Psychology News, 16*(3), 30-34. https://traumapsychnews.com



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Shavonne Moore-Lobban; source: faculty profile

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- Growing a trauma research portfolio.
- Tips for teaching your first trauma class.
- Integrating a trauma focus into your academic department.
- Continuing Education opportunities for developing trauma experts.

SHAVONNE MOORE-LOBBAN
Section Editor
sjmoore10@gmail.com

Question from interested authors are welcome and can be submitted to Dr. Moore-Lobban. Article submissions can also be sent directly to Dr. Moore-Lobban.

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Priscilla Dass-Brailsford; submitted photo

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2. Making important contributions to the scholarly literature in the field of trauma psychology
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4. Demonstrating consistently outstanding clinical work with the traumatized as recognized by international or national groups through citations, awards, and other methods of recognition
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Book Review

Gold, S. N. (2020).

Contextual trauma therapy: Overcoming traumatization and reaching full potential

Review by Bianca Harper, DSW, LCSW, Arizona State University

While the assessment and treatment of **complex trauma** has been examined in a variety of academic and practice settings, there exists an ongoing need to evaluate and enhance current practices by utilizing the **lived experiences** of complex trauma survivors. These nuanced experiences assist researchers and clinicians in better understanding the myriad ways that complex trauma impacts the lives of survivors and informs best practices to foster healing. In **Contextual Trauma Therapy** (**CTT**), Gold provides a unique contextual lens that is critical to understanding the multifaceted ways development is disrupted by complex trauma and strategies to help complex trauma survivors resolve trauma and enhance overall well-being.

Gold's contextual framework provides a **strength-based, collaborative approach** to working with complex trauma survivors. Central to this approach is the necessity to develop a therapeutic alliance that promotes self-efficacy and choice. This client-centered approach emphasizes that **clients are the experts in their own lives** and can teach clinicians valuable information that can help guide case conceptualization and treatment. Additionally, clinicians must intentionally utilize engagement strategies that demonstrate how to develop a collaborative therapeutic relationship. The emphasis on cultivating a collaborative therapeutic alliance and supporting the client in enhancing quality of life, is a tremendous strength of CTT as it encourages clinicians to think beyond typical treatment methodologies.

A core construct of CTT is that **complex trauma survivors are impacted by both the traumatic events they have experienced as well as childhood developmental deprivation resulting from a lack of essential interpersonal resources** needed for psychosocial success throughout life. The focus on two distinctly different aspects of the client's childhood experiences requires clinicians to possess knowledge of developmental and complex trauma literature that can guide their approach to case conceptualization, assessment, and treatment. This premise encourages clinicians to apply ecological and developmental frameworks to comprehensively assess for the impact of trauma as well as how unmet childhood developmental needs are manifesting in the client's life. Gold comprehensively explores how childhood interpersonal neglect significantly influences the psychosocial trajectory of complex trauma survivors. This recognition, in conjunction with the impact of childhood complex trauma, assists clinicians in understanding the need for interventions tailored to the client's unique experiences.

BOOK REVIEW

An additional strength of CTT is how the conceptualization of complex trauma treatment is fluid. Gold challenges clinicians to carefully and collaboratively construct intervention strategies that take into account the contextual history of the client, current challenges, strengths, and coping abilities and revisiting and modifying agreed upon treatment approaches as needed. This perspective allows clinicians to explore diverse treatment strategies tailored to the client rather than feeling bound to a specific manualized approach. Additionally, Gold asserts that trauma processing, while an integral component of complex trauma treatment, should be cautiously approached only when clients have demonstrated a period of stabilization.

Further, he posits that for some clients, **trauma processing is not necessary**. This perspective urges clinicians to make thoughtful and informed decisions, in collaboration with the client, rather than following treatment as usual guidelines. Gold's ability to cohesively merge research and practice expertise, and to integrate both the clinician and client experience, reflects the skill of a perceptive scholar. Gold's intimate knowledge of both complex trauma and psychosocial development is informed by pioneers in their respective fields. Gold builds on the seminal complex trauma work of **Herman** (**1992a**, **1992b**) who provided an initial conceptualization of Complex Posttraumatic Disorder. Additionally, Gold's developmental lens aligns with complex trauma scholars, **Ford & Courtois** (**2013**) who highlight the impact of complex trauma on developmental attainment during particularly vulnerable times in childhood.

Gold provides a **comprehensive overview of complex trauma literature** that can be understood by both seasoned and early career trauma clinicians. While the intended audience of the book is clinicians working with survivors of complex trauma, a wide array of stakeholders could benefit from its contextual content. Complex trauma survivors are likely to find validation of their experiences as the book incorporates client experience and provides insight into both **the impact of complex trauma and developmental deprivation**. Interdisciplinary stakeholders across settings can also utilize the content to inform current and future practices impacting complex trauma survivors.

Gold's extensive knowledge and experience working with complex trauma survivors allows him to understand and eloquently explain the **complexity of client experiences**. This is evident in the successful way Gold bridges the gap between CTT constructs and practice with practical examples, case vignettes, and best practice recommendations. Gold's collaborative, strength based approach to working with complex trauma survivors is a crucial addition to the complex trauma literature as it encourages clinicians to reconceptualize their approach to complex trauma resolution with the individuals that courageously seek treatment in hopes of enhancing their quality of life.

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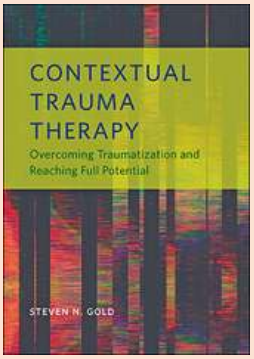

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DIVISION 56 was founded to keep trauma and its effects at the forefront of the conversation within the American Psychological Association. We are focused on bringing together clinicians, researchers, educators, and policymakers to ensure this goal 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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