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DIVISION 56

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

NEWS

Presidential Voice

Carolyn B. Allard, PhD, ABPP

THIS YEAR… Some days it has felt like it has been going by slower than dial-up, but mostly it has gone by faster than a rolling "O," or even like I blinked some time back in March and suddenly found myself in October. Collectively, we have spent and foresee continuing to spend countless hours and energy managing, juggling, troubleshooting, creating, re-creating, listening, reflecting, learning, helping, with no clear end in sight. Our hearts have been broken by so much loss, betrayal, and violence, and buoyed by so much courage, compassion and beauty. Let us each keep being the source of the latter for each other. Please continue to reach out to me or anyone on your Executive Committee with your suggestions of how we can do so at the Division leadership level.

In this, my last newsletter entry as Division President, I would like to take the opportunity to acknowledge and thank everyone who substantially contributed to keeping our regular Division activities going and to new initiatives involving collaborations bridging different arenas of trauma psychology. This includes the entire Executive Committee, of course, as well as all the Chairs and working members of our Committees and Task Forces, who continued volunteering their time to keep the show running during very challenging times. I would like to highlight the efforts of a few specific individuals who truly went above and beyond to ensure that we, as a Division, did all we could to support our members and to use our collective expertise to address current events.

Carolyn B. Allard

Our Executive Director, Katesha Phillips, came on board just as the pandemic did, hit the ground running, and has been invaluable to me and to the Division, supporting the Division through these turbulent times in countless ways. In addition, Katesha was instrumental, along with Webinar Chair, George Rhoades, and the Webinar Committee, in getting our on-demand Webinar platform up and running. Thanks to them, CEUs are now available for many of the APA 2020 convention presentations on the Division Webinar platform. Our convention Program Co-Chairs, Lynsey Miron and Susan Hannan, did an amazing job planning and coordinating essentially two conventions (an in-person and then a virtual one). Jessica Punzo put together some great virtual Hospitality Suite events and Yo Jackson coordinated the Awards Committee's selection and recognition of an inspiring bunch of trauma psychologists during our virtual Awards Ceremony). Our first attempt at celebrating the award winners was sadly impeded by a group of individuals attempting to spread hate and divisiveness. Their attack was hurtful and provided more evidence of how much work we still need to do to eliminate racism (as if we needed more), but it was not successful in stopping us from celebrating these brilliant and compassionate human beings whose work has greatly contributed to our field.

A loud shoutout goes to our fearless and tireless Student and Early Career Representatives, Ayli Carrero Pinedo and Katharine Lacefield. They led the launch of our inaugural Cultivating Healing, Advocacy, Nonviolence, Growth, and Equity (CHANGE) Grant and are coordinating the review process for the over 50 submissions we received. Ayli and Katy have been active members of the Diversity, Equity and Inclusion Taskforce (led by Bryann DeBeer), which is continuing to develop a strategic plan for the Division to engage in program evaluation and improvement efforts aimed at identifying and addressing systemic racism and discrimination within our policies and practices, and to implement reparative practices to redress the balance. Besides the grant, other initiatives already under way include the launching of a Webinar series focused on racism and discrimination related stress and trauma, and paying BIPOC presenters providing trainings on issues related to racism, discrimination, and justice. The first presentation in the Webinar series was focused on Understanding and Addressing Race-Related Stress and Trauma for African American Youth and Adults (presented by Drs. Carter and Dr. Saleem) and is available on-demand (and for CEUs) from our Webinar platform.

The Interdivisional Covid-19 Taskforce (led by Charles Figley, Melissa Wasserman, and Ann Chu) has not stopped developing and disseminating resources focused on crisis intervention, international whole person approaches, hospital and other essential workers, infected individuals and their families, students, support for mental health providers, and intersecting factors (e.g., for immigrants and refugees, interpersonal violence survivors, older adults). In addition, the Division 56 Journal Editorial team led by Kathleen Kendall-Tackett published an immense collection of papers on the effects of the COVID-10 pandemic in the form of studies, literature reviews, clinician reports, and first-person accounts. Articles were written by authors from 28 countries and covered a broad array of topics intersecting with the pandemic, including racial trauma, inequity, health disparities in communities of color, culturally competent emergency management, and collective trauma and community support. The special issue and supplement are available via online open access through the end of the year.

Bryann DeBeer, Social Media Chair, and Kenneth Thompson, Web Editor, helped ensure the Division has a solid and growing presence on the internet and social media, including keeping all of us informed about convention and other Division activities. And last but not least, I want to thank Division Secretary, Loren Post, and Treasurer, Barbara Niles, who made themselves available to work with the Presidential Trio (Elect, Current, Past) to discuss and vote on initiatives needing quick turnaround several more times during the year than what is typical.

I look forward to sharing more information about these and other Division updates at the Membership Town Hall (which will occur before this newsletter goes to press) but I hope you know you are invited and encouraged to contact me or any other member of your Executive Committee any time to ask questions, offer feedback, and provide suggestions for moving the Division and our field forward. I also trust that you are engaging in whatever way(s) you are able to contribute to the eradication of trauma and posttraumatic distress in all its forms, including racism, discrimination, and injustice - and of course this includes taking very good care of yourself. Thanks for doing all you can to ensure next year is a better, brighter, healthier, fairer, and freer one than this year!

Division 56 Listservs

Anyone who belongs to Division 56 is added to **div56announce@lists.apa.org** listserv, for news and announcements. Join any of the following lists by sending an email to listserv@lists.apa.org and typing the following in the body of the note: subscribe name (where name is the part before the @, for example, subscribe div56stu):

div56@lists.apa.org	*for discussion among members*
div56childtrauma@lists.apa.org	*for child trauma topics*
div56ecpn@lists.apa.org	*for early career psychologists networking*
div56stu@lists.apa.org	*for student forum*

Jonathan Cleveland, PhD
Editor-in-Chief

Editor's Note

Dear Readers,

Time has flown by; this issue concludes my three-year tenure as editor of *Trauma Psychology News*. Interacting with delightful Division members and affiliates has been a wonderful experience. I will miss collaborating with my excellent editorial team. Indeed, without Dr. Wyatt Evans, associate editor, and Dr. Jessica Berndt, editorial assistant, creating *TPN* would not have been possible. I am also grateful for the tireless efforts and consistent communications of section editors Drs. Serena Wadhwa & Omewha Beaton (book reviews), as well as Mr. Jack Lennon & Ms. Emily Rooney (student section). A big "thank you" goes out to our three past Division presidents (Drs. Carolyn Allard, Sylvia Marotta-Walters, and Diane Castillo), as well as Dr. Elizabeth Carll (international section) for offering invaluable guidance and for submitting consistently compelling columns. In addition, I appreciate the good work done by Keith Cooke; beyond compiling and formatting, Keith generated the charming spring and fall themes that have been used in recent issues. Finally, thanks to all of the authors and readers who make the newsletter possible!

As I make my exit, I am comforted to know that *TPN* is in steady hands; Dr. Viann Nguyen-Feng has been appointed as incoming editor-in-chief by President Allard. Viann is a fellow at *Psychological Trauma: Theory Practice Research & Policy* and an assistant professor at the University of Minnesota Duluth, where she directs the Mind-Body Care Research Team. She has amassed some 20 publications, many related to trauma; an impressive feat considering she completed her Ph.D. only last year. Viann is coauthor of one of this issue's features, on trauma-sensitive adaptive yoga, and it was her suggestion to invite Dr. Naji Abi-Hashem to be featured in the Whos' Who section. Welcome, Viann!

For a complete listing of the other excellent submissions included in the fall issue, please consult the table of contents. The editorial board at TPN is excited to receive letters, articles, opinion pieces, project updates, deidentified session excerpts, announcements, poems and photo essays. The deadline for the spring issue is Monday, March 8th, with publication slated for late April. Please send your submissions to: traumapsychologynews@gmail.com

With appreciation,
-Jon

Jonathan M. Cleveland, Ph.D.
Editor-in-Chief

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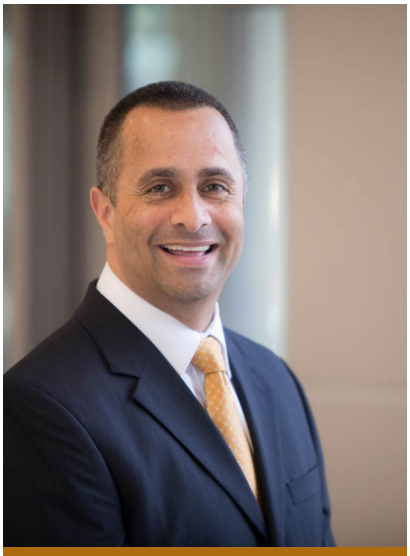
Let's Broaden Our Minds: Making the Case for Mindfulness Skills for Trauma

Vivian Khedari, MA
The New School

Simon A. Rego, PsyD, ABPP, ACT
Montefiore Medical Center/Albert Einstein College of Medicine

Vivian Khedari

Rachel Goldsmith Turow's (2017) *Mindfulness Skills for Trauma and PTSD* is an excellent guide for mental health providers working with trauma survivors. The author presents her own eloquent and well-paced explanations for Posttraumatic Stress Disorder (PTSD) symptomatology and rationale for incorporating mindfulness practice while dexterously integrating sections on scientific research (via "Research Highlight" boxes), patient narratives of their experiences (via "In Their Own Words" sections), and concise instructions of various mindfulness exercises. The result is a pleasantly written and easy to follow resource that goes a long way toward making mindfulness for trauma and PTSD (as well as depression) accessible to any audience.



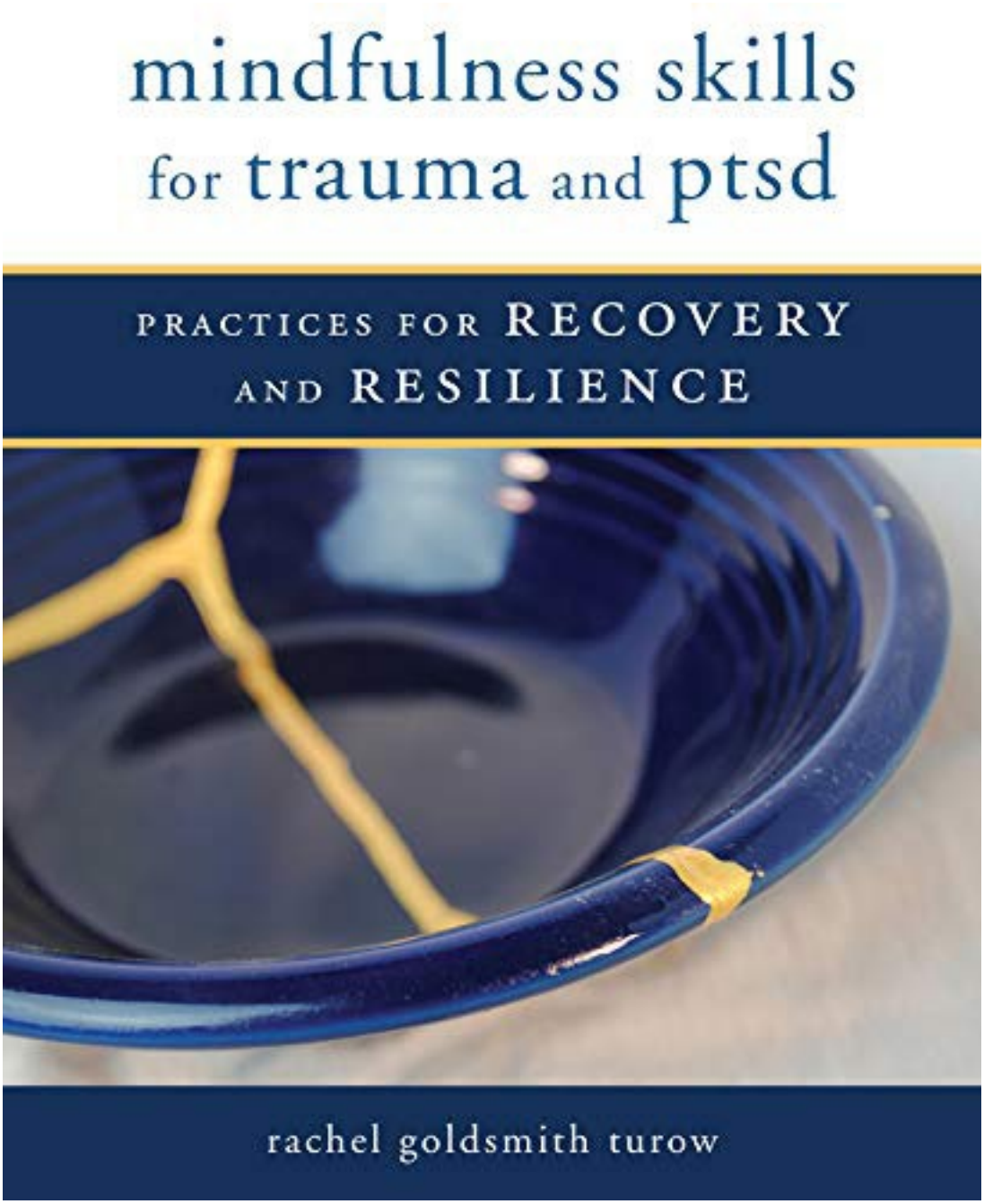
Simon A. Rego

Goldsmith Turow facilitates the use of mindfulness skills to improve PTSD symptomatology, first by providing an overview of the core concepts of mindfulness (e.g., attention, beginner's mind, nonjudgment, etc.), the nature and effects of trauma (e.g., types of traumatic events, common challenges after trauma, etc.), and definitions of PTSD and complex PTSD, and then by smartly presenting the reader with stand-alone chapters that provide specific exercises meant to address each of the DSM-5 (APA, 2013) PTSD symptom clusters (i.e., intrusion symptoms, avoidance, negative alterations in cognitions and mood, marked alterations in arousal and reactivity), as well as dissociation and numbing.

Goldsmith Turow typically presents psychoeducational material at the start of each chapter (related to each chapter's theme), often with both "upsides" and "downsides" to the symptom/approach, and followed by a number of mindfulness practices that can be applied specifically to each post-traumatic symptom. She further divides the exercises between those with the potential to cause immediate relief during a moment of crisis and those that require long-term, sustained practice before resulting in noticeable symptom improvement. This novel approach to organizing the presentation of mindfulness exercises has many advantages. For starters, in line with the clinical understanding that one size does not fit all when it comes to treating PTSD, the way the exercises are organized enables clinicians and clients to pick and choose exercises that are best tailored to their specific and immediate needs. Finally, she emphasizes universal themes, provides a rationale for starting with the "small stuff" and then titrating to painful experiences, and emphasizes practice.

A second advantage of the way the exercises are presented is that in alerting the reader to the exercises' short term vs. long term effect and their symptom specificity, the author avoids frustrating and discouraging them with the unmet expectation that all mindfulness practices should result in an immediate improvement in any and all symptoms. In fact, the author is refreshingly honest in that she does not present mindfulness as a panacea. To the contrary, from the very beginning she is careful to note the limitations of mindfulness. She even goes as far as pointing out that some experiences are not within the individual's own capacity to overcome through individual mindfulness, such as experiences of discrimination or a violent environment.

A third advantage of the symptom-specific exercise presentation lies in its ability to address a common critique and resistance to the use of mindfulness for PTSD symptom improvement. While there is a large body of evidence supporting the beneficial effects of mindfulness on PTSD symptom severity (Boyd, Lanius, McKinnon, 2018) there are practitioners who caution against its use in general, and instead encourage practitioners to



consider each patient's specific symptom presentation and characteristics in order to determine if a mindfulness-based approach would be appropriate (Frewen & Lanius, 2015; Follette, Briere, Rozelle et al., 2015). Specifically, they warn that mindfulness-based approaches may increase distress or destabilize clients who are particularly prone to flashbacks, rumination, or easily triggered trauma memories, given that they reduce avoidance of trauma-related thoughts and emotions and may increase exposure to traumatic memories and emotional states, and may also be difficult for patients who have not developed appropriate emotion regulation or distress tolerance skills (Follette, Briere, Rozelle et al, 2015).With her insightful presentation of exercises specific to symptom clusters, the author is able to advance the discussion past these critiques. She offers, for example, the distraction technique of "changing the channel" and the exercise of "remembering with self-compassion" as short-term and long-term strategies to cope with intrusion, respectively. Neither one of these calls for the typical and quintessential mindful practices that encourage meditation and awareness of the body and emotions, instead these exercises address what the individual needs: a way to work through a moment of heightened intrusions.

Goldsmith Turow (2017) both starts and ends her book with a compassionate invitation towards balancing change and acceptance by finding the beauty of a new baseline or new "normal" that comes after trauma recovery. In the opening section she does so by speaking of the "kintsukuroi", the broken pottery that has been beautifully repaired by filling its cracks with gold or silver. In the ending chapter, she returns to this notion

by speaking of posttraumatic growth and resilience through the lenses of both Buddhist mindfulness tradition and Western psychology. Of note, she expertly summarizes the concept of the "four abodes" (loving-kindness, compassion, sympathetic joy, and equanimity), each with "near and far enemies" and explanations of how to cultivate them using mindfulness and compassion practices.

Despite its many virtues, while *Mindfulness Skills for Trauma and PTSD* is presented as a potential self-help resource, the contents of the text may be used most effectively in conjunction with ongoing counseling. Some of the exercises offered may require more scaffolding and facilitation in order for a reader to engage with them in an effective manner. An example of this would be the author offering the practice of mindfulness during graded exposure in chapter seven ("*Forge Ahead Gently: Mindfulness Practices for Avoidance*"), wherein she briefly explains to the reader how to complete an exposure hierarchy and tracking of subjective units of distress. This exercise, presented as part of a collection of other mindfulness practices that are much more accessible, may oversimplify the theory, challenges and difficulty of completing exposure-based exercises and create an overly ambitious expectation in the reader that, without support, could result in distress and frustration, and, ultimately, potential disengagement from treatment. This limitation may be particularly applicable to patients with high levels of symptoms, which may impact their concentration and verbal learning. Indeed, there is an overall sense that this book, like most self-help tools, would likely be of most benefit to clients with either sub-threshold or mild-to-moderate PTSD.

Notwithstanding the limitations, this book impresses as accessible and validating, seamlessly integrating scientific literature, first-person accounts of experiences, and special considerations, while also addressing misconceptions and stumbling blocks, and providing step-by-step instructions on dozens of different mindfulness practices. Undoubtedly, this text will be useful to clients. In addition, however, it has the potential of becoming a go-to desk reference for clinicians interested in working with trauma, dissociation, and PTSD and, would be equally useful for clinicians interested in expanding their repertoire of mindfulness skills. Taken together, it has the potential to have a positive impact on the lives of many individuals (if it has not done so already). Goldsmith Turow models a compassionate and practical tone with which to speak to clients about trauma and mindfulness that will be incredibly valuable for practitioners working with trauma survivors.

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Vivian Khedari DePierro *is a clinical psychology doctoral candidate at The New School for Social Research, currently completing her psychology internship at Montefiore Medical Center. She first trained as a psychologist at Universidad Católica Andres Bello in Caracas, Venezuela. She has extensive clinical experience working in English and Spanish with children and adults and is particularly interested in the treatment of psychological trauma and working with at-risk youth, forcibly displaced people and immigrants. Her research experience includes the study of physiological markers of complex and acute trauma the U.S, South Sudan and South Africa;x and she recently completed the first RCT of The Field Guide for Barefoot Psychologists - a culturally-informed educational guide that balances psychosocial and biological explanations for the mental-health consequences of forced migration and provides a menu of self-care exercises for refugees - in the Zaatari refugee camp, Jordan, as part of her doctoral dissertation. Vivian integrates her research work into her clinical practice, working through a lens that considers clinical theory, psychobiology and the cultural and sociopolitical context.*

Simon A. Rego, PsyD, ABPP, A-CBT *is Chief Psychologist, Director of Psychology Training, and Director of the CBT Training Program at Montefiore Medical Center and Associate Professor of Psychiatry and Behavioral Sciences at Albert Einstein College of Medicine. He is a former member of the Board of Directors of both the Association for Behavioral and Cognitive Therapies (ABCT) and the Anxiety and Depression Association of America (ADAA). He has over 35 publications (including 2 books), has given more than 165 professional presentations, and constantly works with the media in order to educate the public about the latest mental health news using a simple, non-sensationalized approach.*

"The Canary in the Mine": Re-traumatization and Resilience in Offspring of Holocaust Survivors During the Covid-19 Pandemic

by Irit Felsen, PhD

Older adults are the group most vulnerable to isolation and loneliness even prior to the COVID-19 pandemic, and early data suggest that COVID-19 exacerbated these feelings and might be associated with both an increase in psychological distress among individuals who did not suffer from such symptoms before, as well as an intensification of distress in older adults who suffered from mental health problems before the pandemic (Serafini et al., 2020; for observations from across the globe, see: *Psychological Trauma: Theory, Research, Practice, Policy*, July and September issues, 2020). It is therefore important to recognize potentially vulnerable older adults, such as those sensitized to existential threats and to isolation and loneliness by the impact of intergenerational trauma.

Irit Felsen

Prior research about offspring of Holocaust survivors (OHS) identified particular vulnerabilities associated with intergenerational transmission of effects related to parental trauma, and highlighted the critical role of parental PTSD in determining the burden of transmission in offspring (Danieli, Norris & Engdhal,2016; Letzter-Pouw, Shrira, Ben-Ezra and Palgi, 2014; Yehuda, Schmeidler, Wainberg, Binder-Brynes, & Duvdevani, 1998). While OHS generally function adaptively, specific vulnerabilities which do not necessarily interfere with their daily functioning have been shown become activated in the face of life-threatening events, such as war, serious illness, or the threat of nuclear annihilation (Baider, Goldzweig, Ever Hadani, & Peretz, 2006; Solomon, Kotler, & Mikulincer, 1988; Shrira, 2015). A recent study has shown that OHS with parental PTSD experience more distress and more loneliness during COVID-19 despite the fact that there are no differences in the perceptions of available social support between them and comparison groups (Shrira & Felsen, 2020, in preparation). These vulnerabilities suggest that OHS, who are now almost all over 60 years old, might be especially sensitive to feelings of loneliness and isolation and to negative effects related to the COVID-19 pandemic and to the confluence of crises that followed in its wake.

Since the middle of March 2020, I have been invited by various organizations to present online webinars to groups of adult children of survivors. The sheer numbers of participants who attended such web-based forums reflected a current intensified need among OHS to come together and to process their experiences with others who share the same unique background of historical trauma. In response, over the past months I have offered multiple web-based, free, interactive group 'stand-alone' meetings, which have been attended so far by over 2000 participants. Qualitative observations from these meetings confirm that intergenerational transmission of trauma sensitizes aging OHS to current events, especially to actual and perceived reminders associated with the Holocaust. Subjective trauma-related associations can amplify negative reactions to current adversities. For example, the fact that their age places OHS in at an elevated risk was even more ominous for some participants as it echoed the fact that people over 50 were not likely to have survived the Holocaust (Tammes, 2017). Intergenerational transmission, especially in families with a parent who suffered from PTSD, was also associated in previous studies with more medical conditions in OHS as they reached middle age, reflecting both biopsychological processes and epigenetic changes related to parental trauma (Flory, Bierer, & Yehuda, 2011; Keinan-Boker, 2014). These pre-conditions can expose aging OHS to medical problems when social distancing limits access to non-emergent medical care. Concerns about access to care and in particular, scarcity of food and supplies have been triggers for Holocaust associations. Some children of survivors, averse to memories of their parents' tendencies to hoard food and be always preparing for a disaster, resisted such behaviors. E., a mental health professional herself, said: "I consciously avoided allowing myself to get overly anxious. Perhaps to a fault, numbing myself to what was going on around me. I did not go to the shops, and I refused to hoard food or toilet paper. But then…when there was shortage…I started having thoughts about what might happen and what people might do if there is not enough food in the stores…" OHS have been deeply troubled by the sharp increase in gun sales in the USA. As one woman sharply stated, "we know how neighbors can become murderers".

An overarching sense of hypervigilance and anxiety associated with Holocaust-related associations was experienced alongside a recognition of the hardiness and an inherent preparedness for disaster that was

conferred by the legacy of trauma: "The feeling of doom? I kind of feel this is the feeling I have been expecting my whole life…It is not at all a surprise…"and also: "We are interestingly appreciative while comparing with what our parents went through. This is setting me apart from others [not 2G] who are struggling more. I have the acceptance that things can change within seconds, and I have extreme resources to adapt to new situations…" Commenting on the cost and adaptive value of this hypervigilance, a woman who left her job in Brooklyn when she realized the danger of continued unprotected exposure, while others, including her boss, were still underestimating the risk of COVID-19 and avoiding protective measures, said: "I am like the canary in the mine. I sense things before other people do, I tried to warn them, but I was viewed as an alarmist…" However, participants also expressed that to be always scanning for danger interferes with their sense of well-being and with the family atmosphere: "It's my experience and observation that many of us 2G's are faring better emotionally than others – we are accustomed to extreme situations of threat and danger. The challenge is: how do we live in more 'normal' times?"

The social upheaval that followed the police killing of George Floyd evoked a flood of Holocaust-related associations. Systemic discrimination, audio-recordings and televised instances of police brutality, and images of shattered glass from broken storefront windows called forth "Kristalnacht", the "night of broken glass" between November 9-10, 1938, in which Nazis torched synagogues, vandalized Jewish homes, and killed close to 100 Jews.

While Holocaust associations were prominent in the reactions of OHS, individual responses to direct comparisons with the Holocaust were varied. Acknowledging the tragedies of those personally impacted by COVID-19 and the heroism of first responders, many OHS felt that "this is not the Holocaust!" emphasizing that the current crisis is not the result of malignant intent towards any particular group. Many found the comparison to Anne Frank and the Holocaust particularly trivializing and offensive, stating "we have zoom classes and zoom parties! How can one compare?!"

Social distancing has prevented physical contact with one's family, especially with elderly survivor parents, for many weeks. The reverberations of traumatic separations in the lives of the survivor parents have colored all previous actual and perceived separations in the lives of the second generation, and the responsibility for the parents' wellbeing has been a central theme in the psychological world of the children raised by survivor parents (Bar-On et al., 1998; Felsen, 1998; Prince, 2015; Quadrio, 2016; Scharf & Mayseless, 2011; Shmotkin, Shrira, Goldberg, & Palgi, 2011; Shrira, Palgi, Ben-Ezra, & Shmotkin, 2011; Wiseman & Barber, 2008). The inability to protect aging trauma survivor parents, especially those living in residential facilities, has been excruciatingly painful for OHS.

Of note was the observation that many participants felt they could not be understood by family and friends who are not children of survivors. This theme, expressed by many participants, is particularly relevant as it can exacerbate subjective experiences of loneliness and isolation which are a particular concern regarding the mental health burden of the pandemic (Moreno et al., 2020). Social distancing disrupted many relationships and activities, and a subjective inability to utilize the social support available to them can put OHS at a heightened risk in the face of vulnerabilities that current adversities have activated. Some OHS feared their reactions would be judged as extreme because of their sensitivity to reminders of the Holocaust. Others felt that the difficulties expressed by friends are exaggerated, and people would be offended if they shared that as children of survivors, their perspective is less extreme, based on what survivor parents endured during the Holocaust. Regardless of individual differences, there was an overwhelming sense of comfort expressed by participants about being able to share their feelings with others who are also children of Holocaust survivors, because of the prominence of the Holocaust to their personal experiences and the meanings conferred by it, which others cannot comprehend.

Conclusions

While it will be important to research the effectiveness of such interventions using adequate empirical studies, it is suggested here that web-based groups that emerged as a spontaneous intervention during COVID-19 showed that aging OHS are older adults who are sensitized to trauma-related triggers in the current circumstances and to subjective feelings of isolation due to the experience of not being able to share with, nor to be truly understood, by non-Holocaust-related others. Studies in other trauma-exposed populations have found many similarities in the mechanism of intergenerational transmission and in the outcomes in offspring of survivors (Leen-Feldner et al., 2013; Lambert et al., 2014). Older adults with various legacies of intergenerational of trauma are potentially experiencing sensitivities during these times of uncertainty, turbulence and social distancing. Our observations show evidence for resilience and hardiness and also for amplified anxieties and vulnerabilities related to the intergenerational transmission of trauma. Social support during times of adversity is critical to buffer negative effects and can, in fact, allow re-working of negative internalized mental content that has been activated by current adversities. Psychosocial interventions can buffer the negative effects and also promote resilience and post-traumatic growth in older adults (Feeney and Collins, 2015). Moreno et al. (2020) state: "The COVID-19 pandemic could provide an opportunity to improve the scale and cost-effectiveness of different

mental health interventions," and in order to meet this challenge, sustainable adaptations of delivery systems of mental health care and public health prevention and intervention programs should be developed. The formats of web-based psychosocial meetings of groups who share unique vulnerabilities and interests can offer a "web-based, second-best" sense of community and provide a holding space that offers non-pathologizing social support and psychoeducation, representing a form of effective intervention and prevention for vulnerable groups of older adults when social distancing precludes more direct contact and increases potential distress and loneliness. Equitable access to such interventions needs to be a focus in the preparations for prolonged periods and for future circumstances requiring older adults to maintain social distancing.

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Irit Felsen, PhD *is a clinical psychologist specializing in trauma and traumatic loss. Dr. Felsen has a private practice, and she is an Adjunct Professor at Columbia University and at Yeshiva University, Ferkauf Graduate School of Psychology. Dr. Felsen's clinical experience includes having worked in inpatient and outpatient settings, as well as in emergency psychiatric care, and as a specialist on a national emergency response team. Dr. Felsen is the chair of the working group on Older Adults and Caregivers of the APA COVID-19 Interdisciplinary Task Force and a co-chair of the trauma group of the NGO on Mental Health in Consultative Relationship with the United Nations. Dr. Felsen is a researcher with the Yale University Trauma Study Group, and her published work focuses on the trauma of the Holocaust and intergenerational transmission of trauma.*

Trauma, Disability, and Physical Activity: A Call for Trauma-Sensitive Adaptive Yoga and Wellbeing Programs

Megan J. Sundstrom, BA, Alexa L. Asplund, and Viann N. Nguyen-Feng, PhD, MPH
Department of Psychology, University of Minnesota, Duluth

Nearly three out of 20 individuals, or 42 million people, in the United States report having a disability (Houtenville & Boege, 2019), with these numbers increasing over time (American Community Survey; Kraus et al., 2018). Disability can be broadly referred to as any physical, intellectual, sensory, or developmental impairment (Centers for Disease Control and Prevention, 2019). These impairments affect individuals in multiple dimensions, such as impacting a person's body or mental structure or function, limiting activities (e.g. difficulty with moving, hearing, seeing, social cues, problem solving, etc.), and restricting participation in daily activities (World Health Organization, 2001). Despite the prevalence of individuals with disabilities and potentially traumatic experiences related to disabling events, there is a major gap in the literature on the prevalence of traumatic experiences in this population.

Megan J. Sundstrom

Studies that examine the relationship between trauma and disability have found that having a disability increases the risk of victimization up to 1.6 times (e.g., Chan et al., 2016; for a review, see Jones et al., 2012). For youth, those with a disability are 3 to 4 times more likely to encounter physical abuse, sexual abuse, emotional abuse, or emotional neglect than their peers (Murphy, 2011), with level of victimization and prevalence of clinical depression being significantly higher in youth with disabilities than in youth without disabilities (Berg et al., 2015). These findings have clinical and practical relevance, but more research in this field is sorely needed. Shortages in robust evidence, well-designed studies, and low standards of measurement and assessment have limited the ability to establish factors that contribute to this relationship (Jones et al., 2012).

Disabilities and Mental Health

The combination of trauma history and disability may lead to significant mental health implications that warrant more attention. This significant relationship is likely due to the high comorbidity with disabilities and mental health disorders. Studies have found mental disorders to be just as disabling as chronic physical conditions (Scott et al., 2009), and adults with developmental disorders have significantly increased rates of all major psychiatric disorders (Croen et al., 2015).

In addition to mental health outcomes, those with a history of trauma and with disability are significantly impacted in related areas of their lives. More individuals with a disability live in institutional settings, do not receive a high school diploma, are unemployed, and live in poverty than individuals without a disability (Houtenville & Boege, 2019). Individuals with disabilities are disadvantaged in their social relationships and experience decreased wellbeing, quality of life, and physical health (Howlin & Moss, 2012; Kosma et al., 2009; Rimmer et al., 1996; Wilson & Clayton, 2010). Children with disabilities tend to have an overall lower level of fitness (Wilson & Clayton, 2010), which may manifest itself as health issues later in life. Further, disabled individuals experience higher rates of many medical conditions (e.g., immune conditions, gastrointestinal and sleep disorders, seizure, obesity, dyslipidemia, hypertension, diabetes, stroke and Parkinson's; Croen et al., 2015).

As one might suspect, the evidence described suggests that any disability may have an impact on a person's wellbeing, quality of life, and physical activity and fitness levels (Kosma et al., 2009; Rimmer et al., 1996; Wilson & Clayton, 2010). Despite the impact that a disability may have on an individual, these populations remain underserved and often excluded from communities. Taking action to support and facilitate disabled individuals' integration within society is often lacking, and there has been scarce research on the development of more effective intervention programs (Howlin & Moss, 2012). Therefore, interventions that aim to address wellbeing are especially important for those with a disability.

Wellbeing and Physical Activity Programs

Implementation of such programs that address wellbeing have begun to develop in some areas of the world. In particular, adaptive sports, physical exercise programs, and adaptive yoga programs have been offered

recreationally and as adjuncts to treatment for people with a disability. Of the studies that have examined the effects of these types of programs, many positive health-related outcomes have been noted.

Adaptive sports and physical exercise programs tend to address more of the physical aspects of disability and trauma. Studies have shown that participation in such programs have resulted in increases in levels of physical activity and overall physical fitness and health (Blauwet & Willick, 2012; Zabriskie et al., 2005). In addition to the physical benefits of recreational sports programs, studies have found that the programs benefit the individuals in mental and social domains as well. For example, studies indicate that adaptive sports and physical exercise programs lead to increases in self-efficacy, body image, empowerment, sense of belonging, and motivation for continued involvement (Blauwet & Willick, 2012; Côte-Leclerc et al., 2017; Zabriskie et al., 2005). Such programs have also led to reductions in tension, depression, and anger (e.g., Lundberg et al., 2011). Although these findings show promise for sports and exercise programs, more research is necessary; methodological rigor tends to be low, and mixed results have been found for particular outcomes, including self-esteem, quality of life, and life satisfaction (e.g., Bondar et al., 2019).

Alexa L. Asplund

Some programs strive to address both the mental and physical conditions that stem from disability and trauma experiences. The implementation of adaptive yoga programs have become more popular as a mind-body integrated activity. Studies that compare the effects of yoga to other physical exercise programs suggest that yoga may be even more beneficial and cost-effective at preventing and treating health conditions for people with disabilities than general exercise programs (Cramer et al., 2013; Hartfiel et al., 2017; Saravanakumar et al., 2014). Again, the state of the literature for yoga with individuals who have disabilities is also in its nascency, but outcomes that tend to be studied show increases in exercise capacity, balance, physical function, and health- and memory-related quality of life (Desveaux et al., 2015; Immink et al., 2014; Saravanakumar et al., 2014; Sharpe et al., 2016). Reductions in anxiety and depression symptoms, pain and stiffness, and number of workdays missed due to disability have also appeared to stem from yoga programs (Desveaux et al., 2015; Hartfiel et al., 2017; Sharpe et al., 2016). One such study assessed perceived outcomes in a 10-week yoga program for patients with history of stroke, resulting in increased range of movement, walking ability, strength, calm feelings, and connection to and acceptance of the body (Garrett et al., 2011). Another pilot study assessed a weekly yoga-based mindfulness group for veterans and active duty service members with a history of traumatic brain injury. They found increases in perceived mindfulness, overall health and mood, and self-awareness (Combs et al., 2018). More research is necessary in particularly relevant outcomes, such as motor function, general health, and depression, as studies have found mixed results about the impact such programs have on these outcomes (Chan et al., 2012; Desveaux et al., 2015; Immink et al., 2014; Veneri et al., 2018).

In addition to programs developed for those with a disability, trauma-sensitive yoga is another option for populations with histories of trauma. While yoga has been shown to have an impact on elements of trauma symptomatology, some forms of yoga may be more triggering to survivors of trauma, such as certain poses that remind them of their abuse or that use instructive language from yoga instructors. Trauma-sensitive yoga was developed by the Trauma Center at Justice Resource Center in Brookline, Massachusetts to accommodate the needs of trauma survivors (Emerson et al., 2009). This form of yoga takes into consideration the environment, physical forms, teacher qualities, assists, and language to optimize the experience for survivors of trauma. Strong evidence exists that suggests yoga- and mindfulness-based interventions are beneficial for individuals with trauma history and lifestyle disorders (for a review, see e.g., Taylor et al., 2020). Research on yoga-based interventions have revealed reductions in depression, anxiety, and psychotic symptoms, all of which are commonly comorbid with posttraumatic stress disorder (e.g., Varambally & Gangadhar, 2016). One study found that yoga as an adjunct treatment to psychotherapy resulted in common themes of spiritual healing, increased self-confidence, and increased mind-body connection (Nguyen-Feng, Morisette, et al., 2019b). More high-quality research in this area is needed as well, as a systematic review revealed that the effectiveness of trauma-sensitive yoga as an intervention or adjunct to psychotherapy is muddled by low quality and high risk of bias in studies (Nguyen-Feng, Clark, et al., 2019a).

Research, Practice, and Policy Implications

Psychologists can use this information and generate higher quality research by not only carrying out more studies, but by making sure the studies that are completed are more thoroughly designed. The previously studied outcomes regarding trauma and disability need to be taken into account to design better studies which

should take a multi-modal approach and integrate different approaches to research; for instance, it would be helpful to use mixed-method designs and third-party raters to provide a more comprehensive picture of the trauma and disability experience. Additionally, interventions need to be more clearly defined and holistic, especially for yoga interventions, as the existing research on this topic is lacking. More clearly defined interventions will lead to more thoroughly designed studies and research outcomes that psychologists can use to continue to build their practices aimed at serving disabled individuals.

Viann N. Nguyen-Feng

Psychologists and practicing therapists should think more about integration of physical exercise and yoga programs as interventions to therapy. In particular, an emphasis needs to be placed more on the *ability* in disability. In other words, how can we best serve the particular populations with whom we work, and how can we promote positive outcomes by focusing on enhancing wellbeing rather than overfocusing on decreasing distress?

One possibility to explore for future programs may be a form of combining trauma-sensitive and adaptive yoga programs, especially considering the high co-occurrence between disability and trauma history. For example, while it might be unrealistic for some with a disability to do yoga without assists, a *trauma-informed adaptive yoga* setting may involve asking the participant when they need assistance, checking in with them frequently, and using less commanding instructive language. In that way, such a program would acknowledge the need for a balance between interpersonal trauma and physical limitations by promoting holistic growth.

Making such programs more accessible would be beneficial for many, as this may mean availability of services for practicing professionals as well as affordability and feasibility for clients. For some institutions, this may look like better allocation of funding for programs that promote wellbeing. On a broad scale, it is imperative that policies to promote insurance coverage for wellbeing practices and adjunct programs to psychotherapy be created and enforced. For this to occur, further understanding needs to be placed on the need for more interdisciplinary work, e.g., rehabilitation medicine, psychology. As research suggests, integrating the physical and mental needs of a person's health within the healthcare system provides better outcomes for the individual as a whole. For someone with trauma history, disabilities, a mental health diagnosis, or all three, this is especially important as multiple aspects of their lives are affected by both physical and mental limitations.

Conclusions

Disabilities impair a person's life in multiple ways, relate to increased risk of trauma victimization, and are highly comorbid with mental health disorders. While evidence suggests that any disability negatively affects individuals in many areas of their life, there are still gaps in the research and lack of support for disabled individuals' integration into society. Participation in adaptive physical activity programs that do exist has resulted in improvements in physical, mental, and social domains. Adaptive yoga has emerged as a mind-body activity that may be even more effective than other adaptive sports programs. Trauma-sensitive yoga provides similar benefits to adaptive yoga and is designed to optimize the experience for trauma survivors, although integration of adaptive and trauma-sensitive yoga has not been implemented yet. To best support disabled individuals, psychologists should use this information to continue to build more inclusive practices (e.g., trauma-informed adaptive yoga), conduct more thorough research, and create better policies and systems.

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Megan J. Sundstrom *is a second-year Clinical-Counseling Psychology M.A. student at University of Minnesota, Duluth. Her research interests are centered around psychological wellbeing, mindfulness and mindfulness-based interventions, and emotional abuse. Megan is a Graduate Research Assistant for the Mind-Body Trauma Care Lab and a graduate mentor for first-year graduate student Linda Zheng and undergraduate student Alexa Asplund. Megan enjoys climbing, running, and visiting new places in her free time.*

Alexa L. Asplund *is a student at the University of Minnesota, Duluth, working towards a Bachelor of Science in Biology and minoring in Psychology. She is an Undergraduate Research Assistant for the Mind-Body Trauma Care Lab. Her research interests include working with those whose sociodemographics (e.g., age), medical concerns, or psychological symptoms impact their ability to receive help. This includes working with children, those who have experienced childhood trauma, and those whose help seeking is limited. In her free time, Alexa enjoys golfing, wakeboarding, and playing with her dog.*

Dr. Viann N. Nguyen-Feng *is an assistant professor in the Department of Psychology at the University of Minnesota, Duluth. She serves as core faculty in the counseling/clinical master's program and directs the Mind-Body Trauma Care Lab. For more information about Viann, see her lab website: https://z.umn.edu/MindBodyTraumaCare.*

Public Education in Honduras: How the COVID-19 Pandemic Exacerbated an On-going Educational Crisis

by Rita M. Rivera

The Coronavirus pandemic has aggravated many issues throughout the world. The lockdowns and regulations imposed by different governments have led many to face unprecedented circumstances. Honduras, a country unfortunately known for its high rates of poverty, violence, and inequity, is no exception. Since the declaration of the pandemic in March 2020, the Honduran government mandated complete lockdowns for its entire population of 10 million (The World Bank, 2020). This has led to a spike of unemployment, health and socio-political crises, as well as an exacerbation of the on-going educational crisis.

Rita M. Rivera

Honduras is a country where about 66% of the population lives in poverty (The World Bank, 2020). At the end of 2019, about 375,000 children, between the ages of 6 to 17, relied on the public education system administered by the government (Rivera, 2019). Even before the Coronavirus pandemic, the country faced an educational crisis. In December 2019, reports indicated that out of the 2,339,680 children in the country who were of school age, 14% were not receiving any type of formal education (Rivera, 2019). Despite these statistics being made public, and even though the educational issues have been on-going for more than a decade, there seems to be no change in the system that encourages or enforces parents and caregivers to enroll children in schools. El Código de la Niñez, which is the official Honduran code that protects and oversees the rights of the children, states that every minor under 18 years of age has the right to receive an education. Nonetheless, even though children's rights are legally recognized, they are not truly protected or supported by governmental institutions.

The public educational system has faced many issues in recent years. Overall, the quality of the education is poor, specifically in rural areas of the country. Teachers are often forced to go on strikes because they are overworked and under-compensated. There is also a lack of technical training in most public institutions and children are rarely provided with school supplies or textbooks. In addition to this, the curriculum materials are not adapted to the different ethnic and cultural groups of the country, such as the Garifuna or Creole languages (Humanium, n.d.). All of these obstacles have discouraged caregivers and children. High illiteracy rates have resulted; in February 2020, a month before the declaration of the pandemic, UNESCO's data showed illiteracy rates in Honduras had increased to 13% (Portillo, 2020).

Once the government declared mandatory lockdowns as preventative measures for COVID-19, the public education in Honduras ceased to exist. All of the children enrolled in the public system have been unable to receive any formal education for months. Most of them have become child workers to support their families and, unfortunately, others have become known as "street children." Street children are considered one of the poorest and most marginalized groups in the nation. They often scavenge for food in garbage bins, beg for money at stoplights, or, in worst-case scenarios, join gangs and face risk of violence, prostitution, and drug abuse. Many US news outlets have highlighted how gangs in Honduras substitute formal education and teach children that "crime pays" (Arce, 2014).

In June 2020, local authorities stated that they do not know when the public education system will reopen (Reyes, 2020). The COVID-19 pandemic also poses challenges for students in the private education system. Many of these children are unable to afford technology or Internet services due to the financial crisis that has resulted in their caregivers losing their jobs. Others may have access to a computer or tablet but cannot connect to the Internet due to the constant power outages produced by governmental polices. According to multiple local news outlets that have interviewed parents, caregivers, and children across the country, many citizens have come to accept that the academic year will effectively be lost, with children not receiving any formal education until further notice (Reyes, 2020). In addition, for many poor children, the socio-economic crisis in the nation means that they will most likely never return to school, instead continuing to help their families as child workers.

The COVID-19 pandemic itself is not to blame for the educational crisis in Honduras. Nevertheless, it has exacerbated many issues in the public educational system, exposing millions of children to illiteracy, abuse, neglect, violence, and child labor. The Honduran law

states that children have the right to education, family, and dignity. However, with high rates of child labor and illiteracy, more than 160,000 child orphans, and millions of minors without access to education, it seems that children's rights and well-being are more at risk than ever in Honduras.

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Rita Michelle Rivera *is originally from San Pedro Sula, Honduras. Rita is currently pursuing a Psy.D. in Clinical Psychology at Albizu University, in Miami, Florida, with a concentration in neuropsychology. She is Chair of the Florida Psychological Association of Graduate Students (FPAGS), President-elect of the Florida Graduate Coalition for Medical Psychology, President of Student Council at Albizu University, and Co-chair of several working groups of the APA's Interdivisional COVID-19 Taskforce. Rita's areas of interest include trauma, psychoneuroimmunology, and depressive disorders. She has experience working with Hispanic patients and high-risk populations both in the United States and in Honduras.*

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Working with Trauma in Trans and Non-Binary (TNB) Communities: Brief Review of a Burgeoning Literature Base

by Rebekah Ingram Estevez, M.Ed.

Research with the trans and non-binary (TNB) community across fields and disciplines has increased substantially over the last few decades (Moradi et al., 2016; Valentine & Shipherd, 2018). However, the extant body of work with this community remains in its infancy, with many gaps in empirical knowledge that includes best practices for clinicians working with the unique trauma experienced by TNB individuals and their communities (Burnes et al., 2016; Richmond et al., 2012; Shipherd et al., 2011). Only a decade ago, a special issue of *Traumatology* illuminated the ways trauma scholarship and LGBTQ+ scholarship have been created in silos, thus hindering the development of trauma-focused interventions for a unique population that experiences disparate rates of trauma, violence, and abuse (Brown & Pantalone, 2011). Even less research exists focusing on the *T* in LGBTQ+ communities and their experiences of trauma (Brown & Pantalone, 2011). This is alarming, as TNB individuals are more likely to experience potentially traumatic events (PTEs) such as physical assault (Shipherd et al., 2011) and victimization by overt and covert acts of prejudice and transphobia, such as misgendering and employment discrimination (Kattari et al., 2016; McLemore, 2018; Mizock & Lewis, 2008; Richmond et al., 2012). These experiences each have negative mental health impacts, contributing to heightened rates of mental health disorders when comparing TNB and cisgender individuals (Lefevor et al., 2019). Therefore, it is imperative that psychologists examine the unique experiences and consequences of trauma in TNB communities in order to employ culturally responsive, trauma-informed approaches in clinical practice.

Rebekah Ingram Estevez

Brief Overview of Trauma in TNB Communities

The experience of trauma in TNB communities is unique due to several factors. The "onset" or "trigger" of post-traumatic events' impacts on mental and physical health is located within social structures embedded in the cisnormative culture. Identity-based trauma is often chronic and insidious, experienced within micro, mezzo, and macro-level contexts ranging from transnegative policies to internalized self-hatred and rejection (Matsuno, 2019; Richmond et al., 2012). The Minority Stress Model, theorized first to understand health disparities in LGB communities (Meyer, 2003) and then extended to specify unique stressors of the TNB community (Hendricks & Testa, 2012; Meyer, 2015; Testa et al., 2015) is a helpful tool for clinicians to conceptualize the potential impact of various types of TNB-specific stressors on health and wellbeing. For instance, TNB-specific distal, or external, stressors include workplace discrimination, bodily violence, and non-affirmation of identity (Testa et al., 2015). TNB-specific proximal, or internal, stressors include internalized negative beliefs, fear of future experiences of rejection, and feeling stigmatized due to being misgendered (McLemore, 2018; Meyer, 2015).

Additionally, scholars have elucidated that these distal and proximal stressors exist in various domains, including at the collective or community (e.g., barriers to affirming healthcare), interpersonal (e.g., rejection by family members), and intrapersonal (e.g. pervasive guilt and shame; Burnes et al., 2016; Richmond et al., 2012) levels. Even in the absence of in-the-moment threats to internal and external safety, the cumulative impact of experiencing distal and proximal stressors decreases TNB individuals' accessibility to resilience and coping factors such as accessing social capital, health and socioeconomic resources, social support, and a positive sense of self and safety in the world (Richmond et al., 2012; Shipherd et al., 2019; Shipherd et al., 2011). As Reisner and colleagues contend, "chronic and persistent threats to one's identity…threaten[s] a person's core human needs for trust, understanding, control, and belonging…" (Reisner et al., 2016, p. 2).

It is important to note that the TNB community is heterogeneous in nature, comprised of individuals who identify within the gender binary (i.e., man, woman), outside of the binary (i.e., non-binary, genderqueer), or experience no gender identity at all (e.g. agender; Matsuno, 2019). While research specifying the unique experiences and needs of non-binary individuals is still emerging, extant literature supports that non-binary persons experience unique forms of minority stress. These include misunderstanding and rejection by binary-identified trans communities, skepticism and dismissive attitudes by providers regarding their identity as non-binary, near-constant misgendering through the use of incorrect pronouns, and heightened

levels of discrimination due to nonconforming expressions of gender when compared to binary-identified trans persons (Johnson et al., 2020; Lefevor et al., 2019; Matsuno, 2019). Additionally, Intersectionality Theory, created by Black feminist scholars to elucidate the impact of intersecting systems of oppression, such as racism and sexism, on minoritized individuals (Crenshaw, 1990) is vital in order to fully understand the range of TNB experiences (Reisner et al., 2016; Wesp et al., 2019). Utilizing an intersectional framework, paired with the minority stress model helps make sense of the heightened levels of discrimination, violence prejudice, and subsequent heightened levels of mental health disparities experienced by TNB people of color (TNBPOC; Brown & Jones, 2014; James et al., 2016; Seelman et al., 2017; Singh & McKleroy, 2011).

Clinical Implications

Working with identity-based traumatic exposure has been likened to working with complex post-traumatic stress due to the increased likelihood of exposure to chronic, multi-faceted stressors as described above (Richmond et al., 2012). Emerging findings have reported symptom profiles similar to PTSD and complex PTSD (Courtois, 2004) in TNB identified clients presenting for treatment. These include hypervigilance, difficulty with emotion regulation manifesting as mood disorders, learned helplessness, negative core beliefs about the self, internalization of the "abuser's" (in this case, cisnormative society) belief system manifesting as internalized transprejudice, intrusive thoughts, and difficulty navigating interpersonal relationships manifesting through high rates of interpersonal violence (Richmond et al., 2012; Shipherd et al., 2019). Additional impacts of TNB identity-based trauma include substance use, risky sexual behaviors, non-suicidal self-injury (NSSI), social isolation, suicidal ideation, high levels of guilt, shame, and other negative emotions, sleep disturbances, and disordered eating patterns (Brown & Pantalone, 2011; Burnes et al., 2016; Mizock & Lewis, 2008; Richmond et al., 2012; Shipherd et al., 2019). It is important to note that TNB identified clients might come to therapy presenting with post-traumatic symptom profiles due to experiencing TNB-specific minority stressor(s) from their intersecting identities, and/or due to experiencing traumatic events unrelated to their minoritized identities (Shipherd et al., 2019). Relevant guidelines in the helping professions warn against practitioners assuming that TNB-identified clients' presenting concerns are related to their TNB identity (e.g. Burnes et al., 2010). Thus, it is imperative that clinicians obtain a holistic clinical assessment instead of narrowly focusing solely on the client's gender identity.

While the minority stress model and intersectional framework illuminates various pathways for post-traumatic symptomology, it also shines a light on potential avenues for coping, resilience, and healing trauma in TNB individuals (Meyer, 2015; Singh & McKleroy, 2011). For instance, observed resilience processes essential to healing trauma include connecting with TNB community and TNBPOC communities, garnering familial support, being and having positive role models, creating a self-defined identity inclusive of gender and racial identities, gaining access to affirming medical care, developing a strong sense of self-worth, and engaging in advocacy for self and others (Matsuno & Israel, 2018; Puckett et al., 2019; Singh et al., 2011; Singh & McKleroy, 2011; Stone et al., 2020). As Matsuno and colleagues (2018) reported, these resilience processes operate at the group, community, and individual level, thus helping TNB individuals respond to assaults on their personhood from the micro, mezzo, and macro levels (Matsuno & Israel, 2018). Thus, interventions employed by trauma therapists working with traumatized TNB individuals should be employed across levels and contextual domains as well. Basic tenets of treating complex trauma reactions should be applied, following the phase-based approach described by leading traumatologists (e.g. Courtois & Ford, 2012; Herman, 2015)Judith L</author></authors></contributors><titles><title>Trauma and recovery: The aftermath of violence--from domestic abuse to political terror</title></titles><dates><year>2015</year></dates><publisher>Hachette UK</publisher><isbn>0465098738</isbn><urls></urls></record></Cite></EndNote>

Examples of micro-level interventions include helping the client stabilize through establishing safety and trust within the therapeutic alliance, teaching emotion regulation skills from Dialectical Behavior Therapy and Cognitive Behavioral Therapy, and decreasing maladaptive coping mechanisms such as substance abuse (Burnes et al., 2016; Richmond et al., 2012; Shipherd et al., 2019). Trauma-informed, strength-based perspectives contextualize the symptomology of complex post-traumatic disorders as being the mind's and body's way of self-protection and can be conceptualized with the client as being forms of survival instead of something "wrong" with the client, and can be employed with TNB clients experiencing post-traumatic symptoms (Schwartz, 2020). One way in which clinicians can establish rapport, safety, and trust from the outset of therapy is through microskills such as asking the client for their identified pronouns, modeling use of pronouns, and ensuring all aspects of the therapy environment (e.g., paperwork, pictures and posters) are trans-affirming (Chang & Singh, 2018; Matsuno, 2019; Singh, 2017). Additional micro-level interventions include helping the client identify and challenge internalized negative beliefs regarding their identity, assertiveness training, build positive self-talk, and help the client develop a positive body image and navigate body dysphoria (Singh, 2018). Finally, somatic experiencing modalities can be used to help gender minority-based trauma experienced within the body to help with nervous system responses (Briggs et al., 2018)

Examples of mezzo or group level interventions include connecting clients to peer support groups or group therapy, intervening with family systems to reduce rejection and stigmatization within the unit, ensuring that policies and procedures at the therapist's clinical site are TNB-affirming, and connecting the client with community level resources such as TNB-affirming medical care, housing, and/or legal services (Chang & Singh, 2018; Matsuno & Israel, 2018; Shipherd et al., 2019; Singh, 2018). Intervening at the family-level may be especially important, as recent research has shown the impact of familial support supersedes the impact of other forms of social support and belonging (Puckett et al., 2019). Additionally, the clinician can and should step into roles such as consultant and educator within training programs, hospital settings, schools, and businesses. This should *only* occur in tandem with ongoing personal reflection and growth on the part of the clinician. Finally, fully incorporating TNB-identified individuals within organizations and ensuring leadership positions are held by TNB-identified persons is essential towards ensuring environments are TNB-affirming (Shipherd et al., 2019).

Perhaps most importantly for the healing and liberation of TNB communities are interventions at the macro or community level. Community and Liberation psychologists have criticized individual, internal-level foci of coping with identity-based trauma and have called for radical models of healing and transformation located within communities and social structures (French et al., 2020; Prilleltensky, 2013; Singh, 2016). Racial trauma, while different from trauma due to gender minority stress, operates in similar ways regarding the locus of traumatizing experiences being embedded in culture and systems (Richmond et al., 2012). Therefore, utilizing French and colleagues (2020) definition of radical healing for POCI could be helpful in working with TNB-identified clients, especially TNBPOC clients. Aspects of radical healing in this framework at the macro-level includes practitioners and clients working together to actively advocate for change and disrupt oppressive policies, systems, and structures (French et al., 2020). Additionally, connecting with one's community and embracing collectivism norms and values can help TNB clients normalize their experiences, increase social capital, and feel supported in their advocacy efforts (French et al., 2020; Prilleltensky, 2012). Without changing the *source* of traumatizing events and experiences within society, clients and therapists will be locked in a battle focused on increasing quality of life inside a maladaptive, toxic environment, which will prevent achieving holistic and lasting healing.

Conclusion and Future Directions

While more research is needed to fill the gaps in knowledge regarding best practices for treating trauma in TNB communities, especially TNB communities of color, there is a baseline literature foundation with which clinicians should be familiar. One of the most important contributors to being a culturally responsive, TNB-affirming clinician is ongoing self-reflection into the ways that cisnormativity exists within the personhood, actions, and beliefs of the clinician. Utilizing the gold standard of cultural-competence (awareness, knowledge, and skills; Sue et al., 2019) as a guiding framework for clinician self-work is vital towards being a TNB-affirming, culturally-responsive practitioner. Students and practitioners should also advocate for the inclusion of specific training regarding TNB-affirming practices in training programs. The healing professions have a history of pathologizing and harming TNB communities, and clinicians should be aware that TNB identified clients might enter the therapeutic alliance wary of potentially experiencing harm (Mizock & Lewis, 2008). Finally, in addition to increasing the body of knowledge regarding trauma-informed treatment of TNB individuals, practitioners should step into roles of advocate, disrupter, and accomplice in order to change social and cultural systems of oppression negatively impacting TNB identified individuals while maintaining cultural humility and awareness of the impact of their identities and privileges within TNB spaces.

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Bekah *(she/her) is a current PhD candidate in Counseling Psychology at the University of Georgia. She previously completed her master's in counseling also at the University of Georgia. Her research interests include resilience, the impact of intersectional oppression on mental health, best counseling practices for working with the LGBT community, and examining the lived experience of partners to trans persons of color. Bekah is the co-founder of the University of Georgia's College of Education Trans-Affirming Practices Taskgroup, she provides individual counseling services for a wide range of presenting concerns as a psychologist in training and is involved in advocacy for the LGBT community as a Student Representative for APA's Division 44. Bekah is Project Coordinator for Project AFFIRM, an NIH-sponsored study examining the identity development and resilience of the trans and non-binary community.*

Refugee Mental Health Resource Network: An APA Interdivisional Project

Elizabeth Carll, PhD, Chair

Migration due to wars, conflict, and persecution worldwide continues to unfold, with the number of people having fled internationally or displaced within their country reaching unprecedented levels according to the United Nations High Commissioner for Refugees (UNHCR). In response to this humanitarian crisis, an APA interdivisional initiative was developed to create a database of volunteer psychologists and mental health specialists as there did not appear to be a cadre of trained psychologists for services to the overwhelming numbers in need.

Elizabeth Carll

Training webinars have been developed for the Refugee Mental Health Resource Network (RMHRN) volunteers and others, as training availability for this population is limited and often not included in university training programs. These webinars are now available on demand as Home Study and APA CE is available for those interested in this option. The following 17 webinars are available on demand, with additional ones continuing to be posted. For volunteers of the RMHRN and collaborating Divisions, there is a 40 percent discount on APA CE and the webinars are free.

- Working with Refugees, Immigrants, and IDPs: Telehealth, Use of Interpreters, and Cultural Responsiveness
- Coping with the Disappearance of Family Members during Conflict and War: Missing and Enforced Disappearance Status
- Asylum and Cancelation of Removal Evaluations: Focus on Practical Skills in Providing Testimony in Immigration Court
- Impact and Integration: Psychology's Role in Refugee and Asylum Seeker Cases, and Policy Development
- Intervening with Displaced Children and Families: Refugees, Immigrants and IDP's
- Mindfulness and Meditation Techniques for Vulnerable Populations and Caregivers
- Understanding Differences Between Clinical Trauma Evaluations and Asylum Evaluations for Refugee and Immigration Requests
- Vicarious Traumatization, Stress, and Psychological Resilience: Working with Refugee, Immigrant, and Internally Displaced Populations
- Working with Interpreters with Refugee Populations in Healthcare Settings and for Asylum Evaluations
- Screening and Intervening with Refugees: Understanding Trauma and the Mental Health Needs
- What Happens When Someone is Deported? The Psychosocial Aftermath Experiences by those Deported
- Documenting, Report Writing and Expert Testimony in Asylum Cases: How to Effectively Integrate Information
- An Attorney's Perspective: Best Practices for Collaborating with Attorneys in Support of Immigrant Clients; Writing Effective Medical Affidavits; Testifying in Court; and Understanding Asylum Law
- Asylum Evaluations Continued: A More In-Depth Look at Evaluating Special Populations
- Working with Interpreters with Refugee Populations in Healthcare Settings and for Asylum Evaluations
- Conducting Asylum Evaluations
- Screening and Intervening with Refugees: Understanding Trauma and the Mental Health Needs

The webinars are listed for the RMHRN under the Teaching and Training tab of the Division 56 website.

Who's Who: Naji Abi-Hashem, PhD

First, I would like to thank the incoming editor-in-chief of this periodical, *Trauma Psychology News,* for this interview invitation to share some aspects of my life, work, and journey. I have been active in Division 56 of the *American Psychological Association* (APA) since its beginning. Actually, I may very well have been a "charter" member, back in 2005 or so, when the idea of forming a new division for *Trauma* was gaining support. Since then it received enthusiastic welcome and remained strong till now! Through the years, I had the opportunity to present through this division at many APA conventions and be part of seminars, papers, posters, and workshops. I also was asked to review professional articles for its formal Journal, *Psychological Trauma: Theory, Research, Practice, and Policy*. Certainly, I have enjoyed relating to many colleagues and scholars in this assembly and am happy to call them "my friends."

Naji Abi-Hashem

1) What is your current occupation?

Since early 2000, I have been involved in a number of activities locally and globally, as an independent practitioner—including some teaching and lecturing, counseling and psychotherapy, public speaking, general consulting, editing-writing-publishing, presenting at conferences and conventions, traveling for humanitarian services, international networking, providing training, cross-cultural work, and caring for the caregivers.

Before that, I was a full-time staff psychologist at a clinic in Seattle, Washington providing inpatient and outpatient services, beginning in 1992, for about ten years. Presently, I do a little bit of everything, almost following the moto, "a man of all seasons," since I have broad interests and training in several fields. Although I have frequently received offers for various full or part time positions, I preferred to remain free to follow my passions and be able to travel within the States or abroad on a short notice; I spend several months a year in Beirut, Lebanon, my home country. So, I learned to live on a smaller budget, yet the rewards are greater, as I dedicate myself to higher causes and try to make some contributions on a larger scale.

Depending on the setting, I am usually introduced as a clinical & cultural psychologist, independent scholar, international and cross-cultural worker, author, professor, counselor, etc. I like to consider myself as a "student of the human nature," a "student of culture," and as a "caregiver at large." One of my main passions is caring for those who care for others, especially those working under pressure or on the front lines. These include teachers/educators, counselors/therapists, social workers, healthcare providers, clergy/pastors, lay & community leaders, and humanitarian aid/relief workers.

When in Lebanon, I am usually busy with renewing relationships, speaking engagements, supporting leaders, counseling formally and informally (over meals and walks), teaching intensive courses at a university or seminary level, helping at several orphanages and residential homes for boys and girls, conducting workshops for those serving on the ground, especially among refugees, on topics related to loss, grief, trauma, anxieties, emotional disturbances, and psychosocial welfare (as Lebanon has about 2 millions Syrians and other migrant-refugees populations). Also, in years past I participated in several TV programs, and in 2005 had prepared 13 interview-episodes on Mental-Emotional Health, Psychological Wellbeing, and Pastoral Care.

Through the years, I used to combine countries when traveling but recently have focused on Lebanon due to the needs there. Also, I support two former students of mine (and their teams) who are working in South Sudan and in Cairo, Egypt. Most recently, in early in August 2020, there was a huge explosion in the port of Beirut, of some highly flammable material stored there, which devastated all Lebanese and almost destroyed third of the capital. It was of a nuclear proportion! On top of other accumulated crises in the country, from economic, to political, to financial, to medical, now came the deadly tragedy. Therefore, the suffering is great, and the ramifications are beyond imagination. I have been really sad and burdened, trying to remain very involved from a distance (will travel there soon), helping, counseling, supporting, raising funds, and sharing ideas, resources, and written materials with those working on the ground, helping the injured, the victims, the displaced, and the traumatized.

So, I have an open platform here in the United States and in Lebanon. Sometimes I am torn between the two places, but the technical-digital connections enable me to attend to, remain in touch with, and stay active in both realms as much as possible. However, living and operating in two international settings is both challenging and rewarding at the same time.

2) Where were you educated?

In Beirut, Lebanon and in the United States. I was born and raised in Lebanon, so I was educated in the Arabic-French stream, from kindergarten until the secondary classes (upper high school level), which also offered basic English as a third language on the side. My first college-level degree was in French Language at the Institute of Technology in Electronics (T.S. 1974). I worked for a few years at the American University Hospital in the biomedical engineering department, then pursued another bachelor's degree in Theology, Philosophy, and Biblical Studies at a local Seminary (B.Th. 1980), while strengthening my English toward proficiency. Then, I started course work toward a Master of Divinity at the Near East School of Theology (which later I completed in the US). All the while, I worked full time and serving in the community, before traveling to the USA in the summer of 1983-84 to continue my education and gain a broader international experience.

In two short semesters I finished another B.S. in Psychology (1984) from California Baptist College in Riverside, in preparation for graduate studies in the field. Then, I completed the M.Div. (1985) in Ethnic-Cultural Studies & Pastoral Care from Golden Gate Theological Seminary in N. CA. From there I went directly, with no break, into the Rosemead School of Psychology at Biola University for an M.A. (1987) and a Ph.D. (1992) in their APA Clinical program, with a solid internship in central Pennsylvania in 1991 (ending up with a thick dissertation on the longitudinal effect of grief and bereavement on children and adolescents).

Immediately, I was recruited to join a new clinic in Seattle, Wash., with Inpatient-Outpatient services where I stayed for ten years until I decided to move into free-lance status and pursue my passions full time. Then, I became fully licensed in 1995 and a US citizen in 2005, enabling me to carry dual Lebanese/American passports.

Later on, I became a diplomate and board certified in three minor credentialing agencies. Currently, a member of about 12 organizations and associations, but very active in only a few due to time limitations. I am also an associate with a small *Member Care* non-profit agency, which facilitates the service of psychological-cross-cultural workers. In April 2019, I was honored to be appointed as a *Non-Resident Scholar* at Baylor University's Institute for Studies of Religion (ISR). Virtually, learning never stops, in form of continuing education (CEUs), meaningful interactions, or researching/writing for publications. However, I do remain abreast of world affairs and international developments and discuss these matters with like-minded people to compare notes and gain balanced perspectives.

3) What is most frustrating about your work?

When I worked in clinical settings, dealing with insurance and medical records, and doing piles of paperwork, became an unenjoyable burden. This seems to be increasing in time, causing many healthcare providers to cut down or leave the profession altogether.

Now, in general, what I find frustrating, in a positive way, is my inability to accomplish all the tasks I set to do in a week or a month or a season; when I am making slow progress; when I miss important opportunities and cannot be in more than one place at a time; when I do not use time wisely or plan for much needed proper-self-care (not that I am highly compulsive or stress-driven person); when my body drags behind my mind, ambition, and spirit; when seeing people refusing to be helped or benefiting from the many resources available but rather remaining in their dysfunction; when I cannot respond to all the needs I perceive around me and in the world; when I have to give up some of precious causes or dreams due to the lack of time or energy or resources; and when I cannot respond to all the invitations for speaking, writing, caring, encouraging-supporting, or being there in person on the ground with the suffering people, which I call *"the ministry of presence."*

In addition, what I find agonizing is to behold that the power of darkness and destruction, selfishness and bad intentions, are still at work, in individuals, families, groups, societies, and nations alike, causing deep hurt, pain, and devastation on all levels, everywhere I go. Yet, all these are motivating forces for those of us who are dedicated to diligently bringing a good measure of comfort, healing, restoration, light, and improvement to broken lives, and introduce a welcoming renewal and a constructive change.

To read more interview responses from Dr. Abi-Nashem, please visit the TPN website: http://traumapsychnews.com

Contact & Links:

Email: NajiAbiHashem@gmail.com
http://independent.academia.edu/NajiAbiHashem
https://www.apa.org/pubs/videos/4310843
https://www.apa.org/education/ce/cew0024
https://www.baylorisr.org/scholars/a/naji-abi-hashem/
https://www.researchgate.net/profile/Naji_Abi-Hashem

COVID 19 research study

On February 2020 COVID-19 was officially recognized as a new virus, never before seen in humans. COVID-19 quickly spread around the world, creating a global health and economic crisis. As of February, approximately 2,886,267 people have contracted the virus in the United States and 129,811 have died (WHO, 2020). Despite local efforts to control the outbreak, the US has experienced increasingly high number of cases, with states setting record number of daily infections. Some of those efforts have included sheltering in place, personal protective equipment policies and cessation of non-essential services. Consequently, the measures have increased the unemployment rate in the United States, which is currently at 11.1% (US Bureau of Labor Statistics, 2020).

The social, economic and health consequences of COVID-19 have impacted the well-being of people living in the epicenters off the pandemic. Our community has been forced to physically distance themselves from others and dramatically change their work, school, and social activities for at least three months. According to a recent poll 48% of Americans interviewed are anxious about the possibility being infected with COVID-19. Additionally, 40% of responders are anxious about becoming seriously ill or dying from COVID-19 (American Psychiatric Association, 2020).

ATOP Meaningful World has designed a research study to determine the level of traumatic stress experienced by Americans as a result of the COVID-19 pandemic as well as their levels of post-traumatic growth, meaning-making, and forgiveness. The results from our pilot study are consistent with the emerging data. Half of responders felt anxious and had trouble relaxing as s result of the pandemic, while 80% admitted that they worry too much about different things. Similarly, half of the responders expressed that they established a new path for their lives and experienced changes in priorities from a moderate to a very great degree as a result of the crisis. This last result is consistent with the dramatic changes that our communities have undergone in the recent months.

Participants also experienced growth and showed resilience. Nearly half of responders (40%) expressed that as a result of their crisis they are able to do better things with their life while half expressed that they have a better understanding of spiritual matters (50%). Our aim is to assess our communities well being through time, so we expect to collect data over the course of one year. We expect to obtain further insight on the psychological impact of the pandemic as well as the trajectories for growth that participants will develop over time.

Social Media News

Division 56 is on social media! Please join us to get the latest announcements, news, and events.

Breaking Ceilings Above Broken Ground

Celeste Poe, M.S., LMFT

Like eyes adjusting to the light after a long dark night, this civic unrest has jump started a shock to my system, a restlessness in my mind, body, and spirit that I cannot shake.
My inhales are heavy with desperation. I exhale a tormented, trapped breath. A breath that until recently, has been housed for years within my lungs, as I hear the recent conversations.

Still. Terror lingers just beneath my skin; my body reeking of fear. "You are safe. You are okay." ...and yet... I'm on edge, jittery, and fighting for air.

With headline after headline, I feel how precious each day I have on this earth is, right down to the soles of my feet.
The echoes of these traumas that live within my bones tell me that although more ears are listening, more eyes are watching, and I am not alone, I am still not safe.
My coiled hair remains a beacon, my black skin remains a threat. No matter my surroundings, my knees stubbornly knock together.
For I know in this country, I will never stand on truly solid ground.

Celeste Poe *is a doctoral candidate in clinical psychology at Palo Alto University and a predoctoral fellow in the Yale Child Study Center's early childhood track. Celeste's clinical and research interests include BIPOC mental health, childhood trauma, and pediatric psychology, with an emphasis in early childhood and maternal mental health. She is especially passionate about the prevention and early intervention of intergenerational trauma in underserved families.*

Poem

Joniesha Hickson

I won't even attempt to sleep tonight.
Because,
Like the last several nights,
I know that I will not be able to.

There is a Rage in me that has been boiling for centuries before I came to know my Mother's womb.

I have died a thousand times,
Each time slower than the last.

They want us to walk among them,
Hollow as the tip they send.

Joniesha Hickson *is a 3rd year Clinical Psy.D student at the Chicago School of Professional Psychology. She is a member of several organizations: The Minority Initiative (TMI), The Association of Black Psychologists (ABPsi), and the DC Psychological Association (DCPA). She curates content and social media campaigns for TMI, ABPsi, and the DCPA and is also the DCPA's Diversity, Social Justice, and Inclusion committee student representative. Joniesha founded the 501©3 Non-Profit corporation called Dear Black Prophets, Co. which seeks to work towards Black liberation.*

American Psychological Association
Division of Trauma Psychology
Division 56

2020 Division Council
Elected Positions by the Division and Appointed Positions by the Division President

Executive Committee – Officers of the Division
Elected Positions by the Division

President
Carolyn B. Allard, Ph.D. (Term Ends 12/31/20)
Email: carolyn.allard@alliant.edu

Past-President
Sylvia Marotta-Walters, Ph.D. (Term Ends 12/31/20)
Email: syl@gwu.edu

President-Elect
Tyson D Bailey, Psy.D. (Term Ends 12/31/20)
Email: tdbaileypsyd@gmail.com

Secretary (3 years, renewable for one term)
Loren M. Post, Ph.D. (Term Ends 12/31/21)
Email: loren.post@rogersbh.org

Treasurer (3 years, renewable for one term)
Barbara L. Niles, Ph.D. (Term Ends 12/31/22)
Email: barbara.niles@va.gov

Additional Elected Positions by the Division

Council Representative from Division 56 to APA (3 years, renewable for one consecutive term)
Dawn Hughes, Ph.D. ABPP (Term Ends 12/31/20)
Email: hughes@drdawnhughes.com

Council Representative from Division 56 to APA (3 years, renewable for one consecutive term)
Constance Dalenberg, Ph.D (First Term Ends 12/31/22)
Email: cdalenberg2@alliant.edu

Early Career Psychologist Representative to Division 56 EC (2-year term, renewable for one consecutive term)
Katharine Lacefield, PhD (First Term Ends 12/31/21)
Email: katylacefield@gmail.com

Members-at-Large to Division 56 EC (3 years, renewable for one consecutive term)
Carlos Cuevas, Ph.D. (Term Ends 12/31/20)
Email: c.cuevas@neu.edu

Lisa Rocchio, Ph.D. (First Term Ends 12/31/22)
Email: lrocchio@drlisarocchio.com

Jack Tsai, Ph.D. (First Term Ends 12/31/21)
Email: jack.tsai@yale.edu

Professional Affiliate Representative (2-year term, renewable for one consecutive term)
Julia Seng, Ph.D. (First Term Ends 12/31/21)
Email: jseng@med.umich.edu

Student Representative (2-year term, renewable for one consecutive term)
Ayli Carrero Pinedo, BS, MS (First Term Ends 12/31/21)
Email: ayli.carreropinedo@gmail.com

Journal Editor, Chief
Position Selected by President and Search Committee
Kathleen Kendall-Tackett, Ph.D., IBCLC
Email: kkendallt@gmail.com

Journal Editors, Associates (1 year with auto renew, not past 2020)
Positions Selected by Journal Editor-in-Chief

Sylvia Marotta-Walters, Ph.D., ABPP, Associate Editor
Email: syl@gwu.edu

Sandra Mattar, Psy.D., Associate Editor
Email: sm26@stmarys-ca.edu

Zhen Cong, Ph.D., Associate Editor for Statistics
Email: zhen.cong@ttu.edu

Diane Elmore, Ph.D, M.P.H.
Email: diane.elmore@duke.edu

Tyson D Bailey, Psy.D.
Email: tdbaileypsyd@gmail.com

Paul Frewen, Ph.D.
Email: pfrewen@uwo.ca

Jack Tsai, Ph.D.
Email: jack.tsai@yale.edu

Journal Editorial Fellows
Positions Selected by Journal Editor-in-Chief

Annett Lotzin
Email: a.lotzin@uke.de

Viann Nguyen-Feng
Email: vnf@umn.edu

Rachel Wamser-Nanney
Email: wamserr@umsl.edu

Standing and Ad Hoc Committees
(1-year term, renewable if appointed by incoming President)

Awards Committee
Yo Jackson, Chair (Term Ends 12/31/20)
Email: yjackson@ku.edu

Convention Program Committee
Lynsey Miron and Susan Hannon, 2020 Program Co-Chairs (Term Ends 12/31/20)
Email: div56.chairs@gmail.com

Jessica Punzo, 2021 Program Chair (Term Ends 12/31/21)
Email: midpathpsych@gmail.com

Disaster Relief Committee
Gilbert Reyes, Ph.D., Chair (Term Ends 12/31/20)
Email: drgilreyes@yahoo.com

Early Career Psychologists' Committee
Katharine Lacefield, PhD, Chair (Term Ends 12/31/21)
Email: katylacefield@gmail.com

Education and Training Committee
Bethany Brand, Ph.D., Co-Chair (Term Ends 12/31/20)
Email: bbrand@towson.edu

Janna A. Henning, Psy,D., Co-Chair (Term Ends 12/31/20)
Email: jhenning@adler.edu

Webinar & Continuing Education Committee
George Rhoades, Ph.D., Chair (Term Ends 12/31/20)
Email: dr.grhoades@gmail.com

Fellows Committee
Priscilla Dass-Brailsford, Chair (Term Ends 12/31/20)
Email: pd227@georgetown.edu

Finance Committee
Barbara Niles, Ph.D., Chair (Term Ends 12/31/22)
Email: barbara.niles@va.gov

International Committee
Elizabeth Carll, Ph.D., Chair (Term Ends 12/31/20)
Email: drcarll@optonline.net

Liaison Committee
Jack Tsai, Ph.D., Chair (Term Ends 12/31/20)
Email: jack.tsai@yale.edu

Membership Committee
Irene Powch, Chair (Term Ends 12/31/20)
Email: irenepowch@outlook.com

Nominations and Elections Committee
Sylvia Marotta-Walters, Ph.D., Chair (Term Ends 12/31/20)
Email: syl@gwu.edu

Policy Committee
Diane Elmore Borbon, Ph.D., MPH, Chair (Term Ends 12/31/20)
Email: diane.elmore@duke.edu

Practice Committee
Paul Frewen, Ph.D., C.Psych, Chair (Term Ends 12/31/20)
Email: pfrewen@uwo.ca

Publications Committee
Jack Tsai, Ph.D., Chair (Term Ends 12/31/20)
Email: jack.tsai@yale.edu

Science Committee
*Constance Dalenberg, Ph.D, Co-*Chair (Term Ends 12/31/20)
Email: cdalenberg2@alliant.edu

Lisa DeMarni Cromer, Co-Chair (Term Ends 12/31/20)
Email: lisa-cromer@utulsa.edu

Social Media Committee
Bryann DeBeer, Ph.D., Chair (Term Ends 12/31/20)
Email: bryann.debeer@va.gov

Student Affairs Committee
Ayli Carrero Pinedo, BS, MS, Chair (Term Ends 12/31/21)
Email: ayli.carreropinedo@gmail.com

Other Individual Appointments:

Listserv Manager (appointment by the President and confirmed by EC, renewable every year)
Christopher DeCou, Ph.D. (Term Ends 12/31/20)
Email: decochri@isu.edu

Rachel Wamser-Nanney (First Term Ends 12/31/22)
Email: wamserr@umsl.edu

Monograph Series Co-Editors
Anne P. DePrince, Ph.D. (Term Ends 12/31/20)
Email: adeprinc@du.edu

Ann Chu, Ph.D. (Term Ends 12/31/20)
Email: annchu09@gmail.com

Newsletter Editor (appointed by the President and confirmed by EC for 3-year term, renewable for one term)
Jonathan Cleveland, Ph.D., (Term ends 12/31/20)
Email: jonathan.cleveland@uc.edu

Web Editors (appointed by the President and confirmed by EC for 3-year term, renewable for two terms)
www.apatraumadivision.org
Ken Thompson (Term ends 12/31/23)
Email: kthomps101@earthlink.net

Steven Thorp (Term ends 12/31/23)
Email: steven.thorp@alliant.edu

Task Forces Active (President selects):

APA Refugee Mental Health Resource Network Steering Committee
Elizabeth Carll, Ph.D., Chair
Email: drcarll@optonline.net

Child Trauma Task Force
Julian D. Ford, Ph.D., A.B.P.P., Co-Chair
Department of Psychiatry and Graduate School
Center for Trauma Recovery and Juvenile Justice
Phone: (860) 679-8778
Email: jford@uchc.edu

Carla Stover, Ph.D., Co-Chair
Department of Mental Health Law and Policy
University of Florida
Email: carlastover@usf.edu [old]
carla.stover@yale.edu

Be Part of the Conversation

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 policy makers 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.

Join Us

You can become a part of the Division of Trauma Psychology today by registering online at:

www.apa.org/divapp

*APA membership not required

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Register online at:
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Contact us via email:
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Membership Category	Rate	Journal
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☐ Student without Journal	Free Renew $10	No

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*Professional Affiliate Membership is offered to individuals who are not members of APA. Applicants must submit a description of professional training in trauma psychology or a related field, a c.v., and the name of a current member willing to provide a brief statement of endorsement. These materials should be submitted to the Membership Chair at division56membership@gmail.com

TRAUMA PSYCHOLOGY NEWS
An Official Publication of Division 56 of the
American Psychological Association

EDITORIAL STAFF

DIVISION 56
TRAUMA PSYCHOLOGY
AMERICAN PSYCHOLOGICAL ASSOCIATION

The TRAUMA PSYCHOLOGY NEWS is a membership publication of the Division of Trauma Psychology, Division 56, of the American Psychological Association and, currently, produced three times a year. The newsletter 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.

The TRAUMA PSYCHOLOGY NEWS is distributed to the complete membership of Division 56 and includes academics, clinicians, students, and affiliates who share a common interest in trauma psychology. Unless otherwise stated, opinions expressed by authors, contributors, and advertisers are their own and not necessarily those of APA, Division 56, the editorial staff, or any member of the editorial advisory board.

Editorial correspondence and submissions (< 3,000 words) are welcomed and appreciated. Please submit articles and references in APA style and send, via e-mail, as an attachment in Word format, to traumapsychologynews@gmail.com exactly as you wish it to appear. With their submissions, authors should also include a brief author statement, contact info, and photo at 300 dpi or at least 600 pixels wide by 900 pixels high.

PUBLICATION SCHEDULE

Issue	Submission Deadline	Publication Date
Spring	March 8	Late April
Summer	June 7	Late July
Fall	September 8	Late October

ACCURACY OF CONTENT AND COPY INFORMATION

In an effort to minimize the publication of erroneous information, each chair of a committee/advisory section is responsible for getting correct facts to us on anything related to their committee. The newsletter Editors and the Division's Web Master will only accept materials coming from those chairs. Anything else will be sent back to the chair 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.

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The appearance of advertisements and announcements in the TRAUMA PSYCHOLOGY NEWS is not an endorsement or approval of the products or services advertised. Division 56 reserves the right to reject, edit, omit, or cancel advertising for any reason. Advertising and announcements, as well as copy and artwork, must meet certain size specifications and be submitted in camera-ready form no later than the submission deadlines for the print issue desired.

Ad Size	Rate*
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Half page	$300
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Multiple Insertion Discounts	15% discount for multiple insertions, per publication year, of single ad that are committed and paid in full with initial submission.

*For display ads with color or photos, add $50 each to cost per issue inserted.

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