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DIVISION 56

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

NEWS

Presidential Voice

By Carolyn Allard, Ph.D.

To be sure, 2020 will go down in history (and it is barely halfway through). My hope is that what will earn its place in the history books will be the humanity that shone brightly through the fissures in the fiber of society - fissures that for increasing numbers of us have become impossible to continue to ignore during our forced deceleration and diminished access to distractors due to the Covid-19 pandemic. This stillness has provided us with increased opportunities for observation (outwardly and inwardly focused) and attaining clarity about what really matters, what we are doing in the service of what matters, and what we are doing that results in the opposite of what we want.

I am heartened by the mobilization of millions of people in our country and around the globe toward the shared goals of justice, equality, and the liberation of individuals who are Black, Indigenous, and/or People of Color (BIPOC) from racism and oppression, and indeed of all people marginalized and disadvantaged as a result of White supremacist and related ideologies (e.g., patriarchal, heterocentrist, ableist).

The current Division leadership team shares these goals. As trauma psychologists, we know all too well of the harm caused by the kinds of chronic maltreatment and invalidation perpetrated against people who are BIPOC. We are committed to identifying and dissolving our own individual biases and harmful behaviors and to dismantling racist and exclusionary practices imbedded within the policies and procedures of our division and our other organizations. We have created a taskforce to initiate a deep dive assessment, develop additional actionable steps to continue to address problematic practices, and to elevate BIPOC voices and those of other marginalized individuals. Together with our Student Representative, Ayli Carrero Pinedo, and Early Career Psychologist (ECP) Representative, Katharine Lacefield, the taskforce has already been involved in initiating our Division's Cultivating Healing, Advocacy, Nonviolence, Growth, and Equity (CHANGE) grant to support BIPOC student and ECP member projects. In addition, several Webinars are being organized to more intentionally center and promote BIPOC academics and their work. The taskforce is also charged with establishing a standing committee responsible for ongoing program evaluation and improvement.

Carolyn Allard

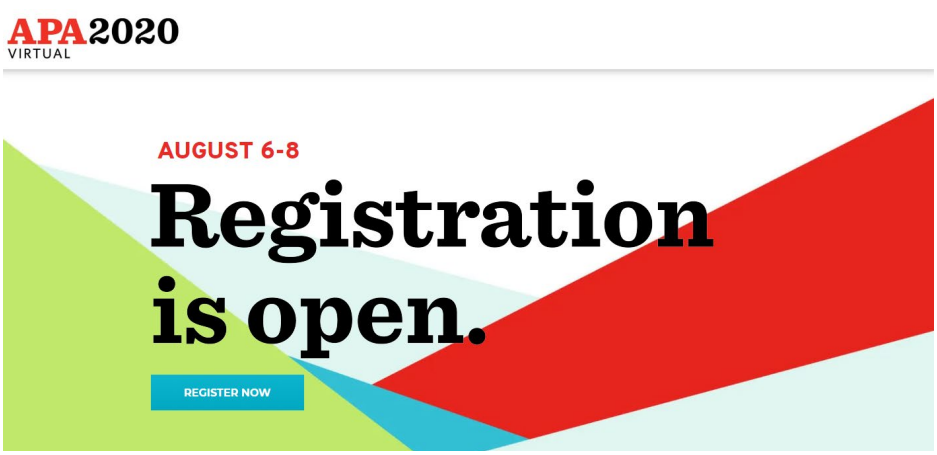
Division members who would like to participate in this effort should contact the taskforce organizer, Dr. Bryann DeBeer.

All the while, we have also been working hard to get the Division program ready for you for APA 2020 Virtual. We are very excited about the prospect of having many more participants than what would have been possible at the live venue given the substantially reduced costs of attending in terms of time, effort and money. In addition, once sessions go "live," they will be available for folks to watch at their convenience. We are also very pleased to be able to offer continuing education units (CEUs) for many of the convention sessions through our own Webinar and Homestudy platform. Attendees will be notified at the start of the presentation if there is a CEU version available with directions for how to access it.

The detailed convention program will be available on our Division Website, and you can look forward to several research symposia, skill building sessions and discussions focused on *Advancing Trauma Research, Practice and*

Policy through Reciprocal Collaborations for diverse populations (e.g., active duty), and don't miss our keynote panels, which will include opportunities to have live interactions with Rev. Mpho Tutu Van Firth and Ven. Thubten Jigme and the panelists who will be engaging in an modeling a courageous depolarizing conversation (Drs. Diane Elmore Borbon, Laura Brown, Steven Hollon, Ani Kalayjian, Pamela Remer, Anneliese Singh, and Paula Schnurr). You are also invited to contribute to recommendations for promoting and increasing expectations of multi-directional collaborations in academic journals, grant agencies, education and training programs, and policy change advocates, in a town hall with Drs. David Bathory, Thema Bryant-Davis, Marylene Cloitre, Anne DePrince, Dean Kilpatrick, and Sheila Rauch.

And that's not all the Division has been up to! The COVID-19 Taskforce continues to develop and disseminate resources, COVID-19 Webinar Series trainings are available on our Homestudy platform, and all of our committees continue to work to keep us updated and to make the Division a resource rich, beneficial, and inclusive home for all trauma psychology students, professionals and enthusiasts. Please continue to reach out to give us feedback and let us know how we can best serve you.



Division 56 Programming for APA 2020 Virtual

Invited Panel Discussions:

- *Transcending Divisiveness: Depolarizing Practices from Around the Globe*
  A live action role modeling of how to have courageous conversations around having different perspectives, followed by live Q&A with audience members. Audience members are welcome to watch the pre-recorded presentations and conversation any time before joining the live Q&A at 3:00-4:00pm EST on 8/6/2020

- *Town hall to Advance Research, Practice and Policy Through Reciprocal Collaboration*
  Audience members are welcome to watch the pre-recorded sharing of experiences and recommendations by panelists any time before participating in the live interactive town hall to offer their suggestions and ask questions at 10:30am – 11:30am EST on 8/7/2020

Skill-building Sessions:

- Culturally Responsive Interventions for Women of Color Survivors of Interpersonal Trauma
- Applying Betrayal Trauma Theory and the Trauma Appraisal Questionnaire to Therapy with Survivors
- Trauma-Informed Supervision
- Promoting a Trauma-Informed Hospital across Various Contexts: Theory and Practical Considerations

Symposiums:

- Trauma-Informed Care: Addressing the Needs of Immigrant Children and Unaccompanied Minors
- Community Support Engagement following Trauma Exposure: Implications for Recovery
- Global Sex Trafficking: Trafficker Profiles, Prevention, and Intervention
- Prevention of Sexual Abuse and Promotion of Emotional Safety in Educational Settings
- Social and Community Factors in Prevention and Recovery from Interpersonal Violence

Division 56 Convention home page: https://www.apatraumadivision.org/30/convention-training.html

Jonathan M. Cleveland

Greetings,

Welcome to the summer issue of *Trauma Psychology News*. Clinicians specializing in trauma treatment find themselves in formidably turbulent times. With all that our readers are doing to help, the editorial team at *TPN* hopes that they are remembering to allocate some time for self-care.

In case you have not yet heard, this year's APA convention is being presented in a virtual format. Not only can attendees access presentations and seminars from the comfort of their own home or office, but the cost of attendance has been greatly reduced (by 85%!). To learn about Division 56's excellent programming, and to access a link to register for the convention, be sure to peruse the previous page.

Our summer issue is overflowing. As you can see from the table of contents, below, we publish a wide range of trauma-related material. Please be encouraged to send letters, articles, opinion pieces, project updates, announcements, poems and photo essays. The deadline for our fall issue is Monday, September 8th, with publication slated for late October.

Best regards,
Jon

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

IN THIS ISSUE

Preventing Professional Trauma Responses

It is well known in trauma research that psychotherapists who work with trauma survivors are prone to their own troubling traumatic responses, such as vicarious traumatization, counter trauma, and secondary victimization. Recognizing that all psychologists are working to help cope with a mass trauma with the Covid-19 pandemic, the Ohio Psychological Association Prevention and Wellness Program began a weekly offering of Self-Care Assemblies for Ohio psychologists in late March. Our program recognized that while psychologists were busy caring for their clients and patients, they needed a safe space to be able to acknowledge the impact of working on the front lines. The Zoom virtual platform allowed us to give our members the opportunity to talk about both what was most stressful and what success strategies they were employing. We helped them to talk about the wisdom they had learned from their experiences with past traumas, whether ones they had experienced themselves or ones they had helped others to cope with. As the pandemic worn on, participants were able to share their own fears, their fatigue, and struggles learning new technology. Whether we had 15 or 5 participants, the assemblies proved to be an effective method of supporting Ohio Psychologists. Most importantly, we helped to create a professional culture that encouraged and supported sharing our vulnerabilities and supporting each other, helping all of us know we needed to lean on each other to get through this marathon, and to prevent any decrease in our own levels of professional functioning.

Howard Fradkin

—Howard Fradkin, Ph.D.

Howard Fradkin, Ph.D. *is the chair of the Ohio Psychological Association Prevention and Wellness Program. He retired from private practice in 2017 after 35 years of helping trauma survivors heal. He currently consults with the Ohio and federal public defender's office about mitigation cases for male and female trauma survivors in the criminal justice system. He is facilitator emeritus of MenHealing.org, a nonprofit offering healing weekends for male survivors of sexual victimization.*

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 email: subscribe name (where name is the part before the @, for example, subscribe div56stu):

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

Wildland Firefighters: Healing Outside the Box

Marilyn Wooley, Ph.D.

Firefighting is one of the most physically and psychologically demanding professions. Wildland firefighters are a special breed. Whereas structure firefighters focus on fire suppression in communities and protecting property such as homes and vehicles, wildland firefighters traditionally fight fire in the forests, fields, and grasslands [United States Forest Service (USFS), 2018]. Firefighters working in cities can go home after shift. Wildland firefighters remain in the wilds, isolated from their families, limited to infrequent phone calls when cell coverage is available, for weeks, even months until the job is done.

A wildland firefighter opines: "Metropolitan firefighters have finesse—they are the show horses, shiny and polished. Wildland firefighters are the down and dirty workhorses."

Marilyn Wooley

The physical demands on wildland firefighters are brutal. Fighting fires in remote areas requires hiking over treacherous geography for long distances before getting to the flames. Temperatures can reach into the 100s. Fire protection suiting protects firefighters from flames but can become stifling. With a fire shelter and gear, a backpack can easily weigh 50 pounds. The risks of these factors can be dehydration, heat exhaustion, even death (Aisbett et al., 2012).

As communities expand into the natural environment, so does wildfire. Both city and wildland firefighters put life safety first, but wildland firefighters now have the onus of saving people in the growing wildland-urban interface. Accessibility in these areas can be difficult making saving lives extremely challenging and dangerous. The enhanced risks to wildland firefighters and consequences of failure have expanded along with the physical and psychological stress they experience (Groot et al., 2019).

The firefighter and wildland fire are in a dance. Two strong personalities in a life or death duel, each battling for control.

Wildland fire behaves like a living thing with moods, hungers, and motivations. On a cool, breezeless day with minimal fuel load in gentle topography by the side of a road, a fire might be fairly docile and amenable to being corralled with a couple of tanks full of water.

But then there are increasingly common superfires, as seen in the past few years largely in the American West. The combination of high heat and unstable air rushing over steep mountain slopes and river valleys leads to enraged and explosive fires. For example, the Carr Fire firenado in Shasta County California in July 2018 detonated into a 42,000-foot, 142-mph, 2700 degree, 1000-foot-wide behemoth that decimated every natural and man-made creation in its path. Imagine a gigantic two-year-old having a screaming temper tantrum, throwing around building structures, crushing electric towers, and scouring the earth with its rage.

A few months later, in November 2018, the Camp Fire descended on the town of Paradise California. Fifty-mph winds drove the fire to swallow football field lengths in seconds. Firefighters abandoned all attempts to save property and made heroic efforts to save lives. Even with their superhero actions, the fire incinerated not only the entire town but dozens of its citizens trapped in their homes or cars as they desperately tried to escape. The intensity of the fire was compared to the firebombing of Hamburg, Germany during WWII. It destroyed power lines, water mains, and the infrastructure and left the entire town uninhabitable. (Wooley, Powell, & Loew, 2019).

Firefighters had never faced anything like these fires. Many described sheer terror they had never experienced before.

A wildland firefighter explains, "In general, the rules of wildland firefighting are simple: put the wet stuff on the red stuff and make a brown stripe between the black and the green. It works that way until it doesn't and then you try something else. Offense, defense, re-engage and start all over. It's not a sprint like a structure fire, it's a marathon, and some days all you can do is retreat."

Wildland firefighters must constantly adapt to the fire environment. All the models in the world cannot predict fire behavior with 100% accuracy because no fire is like another and not being prepared for surprises gets you in trouble. But that is what wildland firefighters appreciate about fire—it is unpredictable.

What kind of person would be attracted to fight wildfire for a living?

Someone active, who likes to be outdoors and is not afraid of physical challenge and brutal work hours. Someone who is willing to live in dirt and smoke and heat for weeks at a time. Someone who can carry a 60-pound pack up steep mountainous terrain in a matter of minutes. Someone who can go without food or sleep for 56-hours during an initial attack. Someone who can survive a fire burning over their engine and keep going. Someone who will risk their life to pull people from burning houses as a fire tornado races hot on their heels.

A risk-taker, optimistic enough to think they can beat impossible odds in order to protect people and property through skill and determination. Someone who would get a tattoo of orange flames rising up their calves just to remind them where they really want to be on their days off.

Leave the fire and then the real challenges begin: Homelife.

A CalFire Captain: "During your shift, you live at the fire house waiting to be called out on a fire. There are rules that you know and follow. It's part of the job. You plan the meals. You cook and clean. You take care of your gear. You know when to relax and when to sleep. You know when you hear the tones go off you respond no matter what time it is, even in the middle of the night. You are constantly ready to go.
"At work, I'm the boss. I earn my crew's respect. They listen to what I tell them. I can count on them to follow my lead. At home, I have to share. It's my wife's firehouse and at best I'm a co-supervisor. During fire season, your spouse and kids have learned to live without you. They go to school or work, the kids' sports, the movies, shopping, whatever, whenever they want. Coming home after weeks on a fire is like coming home to strangers. You walk in and throw a monkey wrench into their schedule. And you can't do an inspection on your kids' messy rooms like you can do with your crew. They don't appreciate your authority like your crew does. Sometimes you think you don't live there."

When wildfires are raging, wildland firefighters spend days or weeks or months in their engines chasing fire. Not infrequently, they fight fires in their own home territory, where their own families and homes are threatened. But they cannot leave the crew and go home to help evacuate. They stay on the job while their families gather their belonging and flee. At times they do not find out that their own home have been destroyed until their shift is over.

Spouses of firefighters may complain that, even when they come home, the wildland firefighter is not present mentally or emotionally. They are absent-minded, distractible, preoccupied, or moody. Tensions rise and the family may resent the firefighter trying to exert some control over the family.

A firefighter explains, "When you're gone for two months at a time, you learn to shut off emotions. They can be dealt with later. When you get home, you're exhausted physically and psychologically. You don't feel like talking. You tell yourself that you're protecting your family by not sharing all you've seen but, in reality, you're too tired to care."

Extreme working hours with no opportunity to relax and recharge can lead not only to physical and emotional fatigue, but significant health problems, addictive behaviors, and increased mortality. Nonetheless, firefighters tend to keep a "game face" because showing weakness is unacceptable.

A wife explains: "After the 2018 fires, he changed. I was afraid he was suicidal and I couldn't leave him alone. If he went outside I'd go looking for him. I felt so alone and I didn't know how to help him."

Children may also be affected by parental absences and parents who are emotionally unavailable when at home. They may feel abandoned and fear for the firefighter parent's safety when they are working. They are more in tune to social media than many parents imagine and are excellent at reading parents' mood. One mother said: "He cries and has tantrums when his father is away. When his father comes home he is either clingy or avoids him for a day or so. Sometimes he even becomes aggressive with his father."

How to help wildland firefighters

During fire season, wildland firefighters cannot often get away for a therapy session. The recent popularity of telehealth sessions can be helpful in accessing services. In recent years, CalFire has brought mental health professionals into fire camps to provide immediate stress reduction and crisis management.

In addition, peer support is invaluable and interested firefighters are encouraged to seek out proper training to be able to provide peer support when necessary. With younger firefighters, social media has decreased the stigma of asking for help.

Families can benefit from employee assistance programs and interactions with other families. CalFire has instituted seminars for spouses to deal with everything from coping with a spouse suffering from a post-traumatic stress injury to negotiating the maze of medical or death benefits.

Community support is essential. During the Carr Fire, one wildland firefighter said, "A 'thank you' sign on a fence post has more impact than anything."

Wildland firefighters face increasing physical, psychological, and social pressures as wildfires become more dominant and ferocious in many areas. During the fire season, they are isolated from family and support systems. Traditional forms of treatment do not fill the need and creativity is necessary to offer them and their families crisis management, family support, and accessibility.

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Marilyn J. Wooley, Ph.D. *is a clinical psychologist specializing in treatment and crisis intervention for law enforcement, firefighters, communications dispatchers, and emergency medical personnel. She has volunteered as a lead clinician for the West Coast Posttrauma Retreat/First Responders Support Network since 2001. Wooley lives in Northern California and survived the Carr Fire Tornado. She is working on a manuscript about post-traumatic growth in first responders.*

Division 56 Member Services

Join Division 56: join.apa.org/divisions

Website: www.apatraumadivision.org

Listservs: Everyone is added to the announce listserv, div56announce@lists.apa.org (where news and announcements are sent out; membership in Division 56 is required). To join the discussion listserv, div56@lists.apa.org (where discussion happens; membership is not required), send a note to listserv@lists.apa.org and type the following in the body of the note: subscribe div56

Journal: You can access the journal, *Psychological Trauma: Theory, Research, Practice, and Policy,* online at www.apa.org via your myAPA profile. Log in with your user ID or email and password.

Newsletter: The newsletter is sent out on the division listservs and is available on the website at http://traumapsychnews.com/

Membership Issues: Email membership@apa.org or phone 1-800-374-2721.

Mental Health Challenges of a Global Pandemic: The Case of COVID-19

Dr. Ani Kalayjian, Jasmin Guevarra, and Erin Antona

Introduction

Towards the end of 2019, the outbreak of coronavirus (COVID-19) began in China and quickly spread to other countries within months. COVID-19 is an infectious virus that easily spreads with mild to moderate symptoms, mainly infecting older individuals with underlying medical problems (WHO, 2020). By March 11, 2020, the coronavirus became a global pandemic according to the report put forth by the World Health Organization. By March 13, 2020, it was declared a national emergency in the United States (CDC, 2020). The United States became the epicenter of COVID-19 and by June 2020, there were 1,920,904 total cases and 10,990 total deaths (CDC, 2020). In order to slow down and eventually stop the spread of the virus, the government implemented a series of guidelines such as quarantine, social distancing, wearing facemasks, and wearing gloves. For the sake of this paper, social distancing will be referred to as 'physical distancing,' as the popular saying "social distancing" is not a healthy statement. We as humans, are a social animal, and thrive with positive social support.

Ani Kalayjian

As we emerge into a new way of living in order to cope with the pandemic, mental health has become a major issue amongst people of all ages. Students have to adjust overnight to an online learning environment and many parents have to work from home if they still have employment. Domestic violence and abuse rates have risen to 30% in France and 18% in Spain, China, and the U.S. (Duncan, Weaver, et al., 2020). Additionally, grieving the death of loved ones from the coronavirus has become extremely challenging.

The Association for Trauma and Outreach (ATOP), MeaningfulWorld, has spearheaded free weekly zoom support groups since mid-March to help strengthen those that are struggling. The goals of the support groups were to help discharge negative feelings; transform fear, anxiety, and worry to lessons learned; and to help communities at large. This article will examine the mental health challenges entailed in coping with a global pandemic.

Literature Review

A study in China has revealed signs of psychological distress caused by the crisis of COVID-19 . The study measured the peritraumatic distress of the general Chinese population by conducting the country's first large-scale nationwide survey (Qiu et al., 2020). The questionnaires used in this survey measured the frequency of anxiety, fear, worry, depression, and other symptoms that might indicate struggles with mental stability during the pandemic. The results of the study showed that 35% of the population showed signs of psychological distress. The highest levels of psychological distress were shown in migrant workers and also in women, young adults, elderly, and individuals with higher education (Qui et al., 2020).

Moreover, multiple factors impacted the outcome of this research. These factors are:

1. Higher scores of distress in young adults due to excessive use of social media.
2. Higher scores in elderly due to high mortality rates in this age group.
3. Higher levels of stress in women.
4. Level of education (individuals with higher education tended to be aware of their mental health issues and seek assistance).
5, Higher scores in migrant workers due to income hardship and high exposure to the virus as they utilize public transport (Qui et al., 2020).

Other factors highlighted in this article were availability of local medical resources, efficiency of the regional public health system, and prevention and control measures taken against the epidemic. The study emphasized the importance of mental health services during the crisis of COVID-19 in China (Qui et al., 2020).

The panic of the pandemic from the public is not the only cause of mental health challenges. Healthcare providers have also been experiencing emotional distress not only due to the high exposure to the virus, but also due to the traumatic experiences that are associated with providing care for COVID-19 patients (Pfefferbaum et al., 2020). It is also evident that the stay-at-home order, although necessary, has also caused some individuals

to experience the following psychological symptoms: anxiety, irritability, fear, frustration, depression, isolation, and insomnia (Pfefferbaum et al., 2020). Not only has the physical isolation been challenging, but the lack of supplies and medication, as well as the general financial depression has tended to exacerbate levels of distress. Furthermore, those who have lost loved ones from COVID-19 are also impacted with grief, especially since they must grieve in isolation (Pfefferbaum et al., 2020).

Jasmin Guevarra

The emotional impact from this pandemic has caused higher risk of suicide. Head of Trauma at John Muir Medical Center, Dr. Mike deBloisblanc, reported that the number of suicides in the month of May were equivalent to the number of suicides reported in a year (Hoonout, 2020). The effects of the pandemic can be damaging to those who already live with a mental illness. Fear from the pandemic as well as the psychological effects of physical distancing can put those with mental disorders at higher risk of suicide (Gunell et al., 2020). Others with no prior mental illness have been susceptible to developing high levels of post-traumatic stress disorder.

As mentioned earlier, healthcare providers continue to be heavily impacted emotionally by the global pandemic. It was reported that a top E.R. medical doctor, Lorna M. Breen, completed suicide after witnessing the horror of the virus (Watkins et al., 2020). Healthcare workers not only struggle with the influx of patients in a short period of time, but they are also lacking the equipment to treat it. There has been a shortage in personal protective equipment (PPE) in the United States, which puts healthcare workers at a higher risk of being infected by COVID-19 (Watson & Juman, 2020). Additionally, healthcare workers have to comfort COVID-19 patients by acting as a family member, due to the risk of exposing the virus to the patient's loved ones (Watson & Juman, 2020). These are factors in the psychological distress that frontline medical workers are experiencing. We have also been notified of several suicides taking place in our communities.

Rates of domestic violence and alcohol consumption have also risen, and these are known to be precipitants of suicide (Gunnell et al., 2020). In a recent study, the United Nations projected about 15 million new domestic abuse cases worldwide (Ott, 2020). The United Nations has already reported a rise in domestic abuse cases to 32% in France, as well as rise in cases in Argentina, China, Germany, Turkey, Honduras, South Africa, the UK, and the United States ("UN backs global action to end violence against women and girls amid COVID-19 crisis", 2020).

What is the United Nations Doing?

The United Nations has always been a helping hand in making the world a better place. Since the beginning of the coronavirus pandemic, the United Nations included a separate site within their main website to feature news related to the global health crisis. On this site, there are specific tabs for announcements from the Secretary-General, Stories, News, and several resources, including for women and youth.

On the Secretary-General tab, António Guterres, has daily updates on how COVID-19 has impacted many world issues. Specifically, on May 15, 2020, Guterres declared the need for action on mental health during this pandemic. Throughout the report, the Secretary-General stated that we must stand by individuals who are frontline healthcare workers, older people, adolescents and young people, and those with pre-existing mental health conditions (2020). As we may begin to see an increased need for mental health services in the upcoming months, the government must fully fund and expand on aiding these areas, since mental health is an essential part of government responsibilities (Guterres, 2020).

In an effort to increase mental health stability while living through a global health struggle, the United Nations, #CopingWithCOVID, released a webinar series on young people and mental health. Since young people have had many of their social environments like school, sports, and seeing their friends daily taken away from them, this webinar focuses on how to overcome the battle with "socializing" from a distance. The Secretary-General's Envoy on Youth and UNICEF gives about an hour long tip segment on building stronger connections during COVID19. The webinar began on April 1 and will continue until July 22. Along with video sessions, there is a Q&A on specific topics. This webinar provides a common space for many people who are going through the same issues to come together.

What is ATOP Meaningfulworld Doing?

Since mid-March, ATOP Meaningfulworld has been providing weekly support groups every Thursday at noon, EST. Here are some of our observations of the 3-month long support groups. In each support group there were around a few dozen participants. Participants were 99% women, mostly university graduates or students (90%), majority from United States of America (90%), the remaining from UK, Pakistan, Lebanon, India, Armenia, and Haiti.

The following post-traumatic symptoms were frequently rated extremely high on the emotional thermometer of 0-10, (10 being the most severe): Fear, worry, anxiety, frustration, disappointment, helplessness, sadness, sleep disturbances and nightmares.

Although we cannot change what has happened, the pandemic, we can strive to learn from it. Any crisis brings with it both danger and opportunity. Opportunity is for learning a positive lesson, while danger is when we do not cease the moment, we do not learn from it, and we repeat the same suffering in the next pandemic (Kalayjian, 2018). According to Frankl (1965), there are positive lessons to learn even in the worst, most traumatic situations.

Erin Antona

What are the positive lessons to learn? Our support group participants shared the following lessons: "I learned that I could rely on my family," "I know I could connect with Mother Earth," "It is a new situation, I am going to learn from it," "I am grateful that I could breath, and have enough food," "I am free now to focus on my inner health, to shine my inner light," and "I am enjoying helping others, as when I help others, I feel less helpless, and can cope with uncertainties."

Resources for Free Support

Technology is one of the great resources we have in our everyday lives, and our phones offer numerous applications that could help with our mental health. The application, *Mindfulness*, gives many different meditation sessions for sleep, emotions, relationships, and more. Another application called *Jour* is a self-care journaling application where you can write down any stressful issues you are going through to let it out. The *Jour* application also has specific topics and prompts if you do not know how to begin writing. Most self-care applications also offer a daily reminder notification just in case you forget to start your day off with meditation or journaling.

Exercise is a second beneficial resource that is not only essential for physical health, but is also necessary to care for one's mental health. In particular, yoga has become a popular practice in reducing stress and relieving anxiety. It has also been used to care for various different psychiatric disorders around the world. Yoga practices incorporate mindfulness, which is proven to have many cognitive benefits. It is easy to practice yoga in the comfort of one's home. On the MeaningfulWorld YouTube channel, we host a series of videos where we provide healing, support and relief through the yoga practice of "Soul Surfing." The Soul-Surfing practice integrates the physical movement, with deep diaphragmatic breath, color consciousness of each energy center, chakra balancing, and positive affirmations repeated for each movement. In less than 20 minutes, through Soul-Surfing we can align our body, mind, and spirit. These exercises are best to do at the minimum 3-times per week (Kalayjian, 2018). "Exercise in Times of Global Pandemic: Soul Surfing" :https://www.youtube.com/watch?v=nk-aedntLWs" https://www.youtube.com/watch?v=nk-aedntLWs.

Meaningfulworld has also been offering all day workshops to those who wish to study the human nature and learn about integrative self-care practices, peace building, forgiveness, and mindful leadership. These workshops are once a month, http://meaningfulworld.com/.

Additionally, Meaningfulworld has compiled a list of resources, which is posted on our website, and is also offering free therapeutic sessions for those in need. The American Psychological Association's Trauma Division spearheaded a COVID-19 Task Force, with the partnership of many other divisions, to address the needs of the populations impacted by this virus and its psychological impact. The New York State Psychological Association also has resources. The first author has delivered a recent webinar on the varieties of trauma (Kalayjian, 2020). Additionally, NYSPA has free support phone line and offers a follow up 6-therapy sessions, which are pro bono (DNR, 2020).

Conclusion and Recommendations for Further Research

Based on the review of literature, personal sharing, support group sharing, and other case studies, we conclude that as a human race we are suffering from many negative impacts of the COVID-19 pandemic. We recommend further research to explore the various mental health and psychological challenges of collective trauma before another pandemic irrupts. We also see that when humanity is suffering from mental health issues, these challenges impact the collective psyche of humanity, and extreme emotional outbursts could follow.

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Hablar Es Sanar: Reflections on a Trauma Healing and Wellness Group for Latina Women

Alyssa L. Kennedy, Kelsey Kuperman, and Darien Combs
University of Oregon

Immigrants are the fastest growing population in the United States (U.S.), with more than half of the 44 million foreign-born residents and 11 million undocumented immigrants being from Latin America (Passel & Cohn, 2019; Radford & Noe-Bustamante, 2019). Thus, increased access to culturally responsive mental health services in Spanish for marginalized Latinx communities is paramount. In pursuit of this work, we have collaborated to develop and facilitate *Hablar Es Sanar* (*Talking is Healing*), a community-based and trauma-focused mental health and wellbeing support group for Latina women. This group derives from a critical, increased need for quality services that are not only in Spanish, but are also tailored to meet the unique needs of Latina immigrant women.

Alyssa L. Kennedy

Many Latinx immigrants have lived through war-related trauma, political and gendered violence, and life-threatening situations during the migration journey to the U.S. (Martínez, 2014; Vogt, 2013). Once in the U.S., Latina refugee and immigrant women commonly report loneliness, isolation, and difficulty creating trustworthy and supportive relationships (Hurtado de Mendoza et al., 2014). For these women, interpersonal relationships and social networks are imperative for enhancing resilience (Goodman et al., 2017), protecting against depression (Hovey, 2000), and reducing the negative effects of economic and social stressors on health outcomes (Ornelas et al., 2009). Further, social support has been shown to buffer against the impact of trauma on mental health (Charuvastra & Cloitre, 2008). *Hablar Es Sanar* was designed to help foster a strong sense of community and serve as a source of social support, while also providing an inclusive space for Latina women to feel comfortable discussing shared life experiences, learning from one another, and healing together in community.

Group Format, Topics, and Structure

To provide context, *Hablar es Sanar* is housed within a local non-profit organization that provides trauma-informed healing and wellness services. The group, which we have facilitated for two years, consists of weekly, two-hour long sessions in 10-week cycles.

To facilitate accessibility, *Hablar Es Sanar* remains "open," such that new members can join at any point in a cycle, with an average of 5-7 attendees each week. The group structure was adapted from the "Manual de Salud Emocional" (García et al., 2009), a curriculum designed by the Jesuit Migrant Services in Mexico and the Universidad Iberoamericana Puebla to enhance cognitive tools for women whose family members had immigrated, which includes an adapted version specifically for immigrant women in the U.S. (Lundy et al., 2017). Building upon these resources, *Hablar Es Sanar* covers a range of topics based on group members' requests, including emotion regulation, trauma healing, immigration-related stress, intersecting identities, interpersonal violence, self-care, and self-compassion.

Regarding group structure, each session begins with a "check in," consisting of a one-word description of their emotional state and one question related to the previous week's topic. Then, after an interactive activity that encourages movement and/or creative expression, we introduce a new topic, which we discuss and reflect on as a larger group or in pairs. Last, to close the group, we have a "check out," which includes another single-word description of the group members' current mood or emotional state, as well as a short reflection of that day's group or goal for the upcoming week.

Community Ties and Logistic Foundation

In addition to creating structure, we have realized that the success and sustainability of our work depends heavily upon our consideration of context. In forming the group, it was essential for us to consult with community stakeholders, such as providers with intimate knowledge of and access to the local Latinx community (Goodman et al., 2017), in order to understand and meet existing needs. Further, we collaborated with treatment coordinators and providers who were aware of ongoing services and treatment gaps. These consultations not only allowed us to ensure the relevance of the services we provide (i.e., avoiding scheduling conflicts with other services, integrating trauma-focused concerns), but also facilitated continued dialogue and built trust with providers and community members. Of particular importance was receiving endorsements from trusted providers in the community to increase the likelihood of members attending their first group. From there,

we have continued to integrate input from both group members and professionals in order to adapt services to better meet group members' needs, increase accessibility, and remain sustainable long-term. For instance, in response to feedback, we have incorporated new content, altered the type of food provided, and, more recently, transitioned to a more accessible online platform during the COVID-19 crisis.


Kelsey Kuperman

A mentor once gave us the helpful insight that, from an equity standpoint, services for under-resourced communities will require additional resources and support for successful engagement. We have found this approach to be crucial for the group, given that many participants are working, financially under-resourced, mothers, and providers for their families. In order for these women to attend our evening sessions, it has been vital for us to provide food and childcare at every group. Providing dinner aims to reduce barriers and allow participants the time needed to attend the group by removing the need to cook or take care of their children that evening. Breaking bread together at the start of each group has also encouraged community building and a welcoming transition into the session. Additionally, we have found that the children's enthusiasm to attend childcare, as well as group members' ability to take a break from caregiving to focus inward have served as powerful motivators for group attendance. Thus, rather than being additional perks of the group, food and childcare are viewed as indispensable components of the intervention itself. Contextual factors such as these are critical considerations when designing and implementing accessible, supportive services for community members.

Interventions: Mind-Body Connection and Healing through Interactive Activities

The consideration of cultural and contextual factors is also crucial for understanding human suffering and supporting psychological healing. Our intention is to make the group as contextually informed as possible to align with group members' life experiences, while also incorporating relevant research to shape group interventions and activities. For instance, research suggests that stressful and traumatic life experiences not only impact mental health, but can also have significant physical consequences on the body (Pascoe & Richman, 2009; Silver et al., 2018). Further, the expression or manifestation of psychological or emotional distress in one's body is culturally normed and more commonly reported among Latinx groups as compared to other racial/ethnic groups (Canino, 2004; Sirin et al., 2015). This is highly relevant to our work, given that many of the women in *Hablar Es Sanar* are significantly impacted by immigration- and acculturation-related stress, varying forms of trauma, and ongoing, everyday stress.

With these factors in mind, we are more cognizant of the ways in which traumatic and stressful life experiences can disrupt group members' experiences of and relationships with their bodies. For instance, a common stress response is for individuals to feel less grounded in the present moment and more disconnected from their physical being. Therefore, we have incorporated an interactive element in the group aimed at encouraging physical movement, creative expression, and healthy mind-body connections. Interactive activities include mindful breathing exercises, intentional stretching, yoga movement, and "ice-breakers" involving dance or creative expression. Further, group members are asked to identify physical sensations (e.g., muscle tension, temperature, pressure/contact, feelings of ease or discomfort) before and after engaging in these movement activities. By checking in and noticing any physical changes, group members can develop useful grounding strategies, greater present-moment awareness, and stronger mind-body connections. Not only has physical movement been shown to facilitate trauma healing (Dieterich-Hartwell, 2017), but the strategies gained through these practices could also be applied to everyday coping (e.g., emotion-regulation, stress-management, increased comfortability with being present in one's physical body).

Reflections on Identities and Cultural Humility

Through the process of co-facilitating the group, it has been imperative for us to critically reflect on our own identities and the intersections between our identities and those of group members. For instance, while our gender identities as females align with those of group members, our racial/ethnic backgrounds and much of our lived experiences differ from participants', given that we neither identify as Latina nor immigrants. Further, while all facilitators are fluent in Spanish and have spent time working in Latin America, we are second-language Spanish-speakers. In acknowledging these differences, we are aware of the unique challenges that group members face, including navigating cultural and language barriers in the U.S., coping with xenophobic prejudice and discrimination, and managing fear and uncertainty related to legal status.

Our ongoing, critical reflection of shared and distinct identities and life experiences has required humility and cultural responsiveness through every step of the

design, coordination, and facilitation of the group. This work also calls for an openness and willingness to recognize and take ownership of our mistakes along the way, as well as a continued commitment to educating ourselves, examining the influence of our power and privilege on group interactions, and holding one another accountable in the process. We have also strived to honor the Latinx values of personalismo (i.e., an inclination for warm yet formal relationships), confianza (trust), and respeto (respect) to create a safe and nonjudgmental space for group members to share in community (Sue & Sue, 2015). To deepen reflection and increase accountability, we check in with one another following each group to highlight successes and identify challenges and areas for improvement. Additionally, we receive weekly bilingual group supervision, engage in consultation with a Latina immigrant psychologist, conduct periodic check-ins with group participants, and provide opportunities for anonymous feedback after the completion of each 10-week cycle.

Darien Combs

Concluding Thoughts

In reflecting on the impact of *Hablar Es Sanar*, group members have shared, "*Sé que merezco estar bien y feliz*" ("I know that I deserve to be well and happy"), "*[Tengo] confianza para compartir cosas que no puedo compartir afuera*" ("I have the confidence/trust to share things that I can't share outside"), "*Mi alma y mi mente están más estable*" ("My soul and my mind are more stable") and many other similar experiences. As multiculturally-trained clinicians and soon-to-be counseling psychologists, we are profoundly grateful for the opportunity to work with, learn alongside, and strive to enhance culturally responsive services to this highly resilient and underserved group of Latina women. The purpose of this article is not to provide a blueprint for designing and implementing a trauma healing group in Spanish, but rather to engage in the collaborative, ongoing process of sharing ideas, critically reflecting, and learning from our experiences as part of a larger community of providers, educators, and society members.

Through our applied work, we have learned the importance of (a) integrating evidence-based practices and cultural adaptations to inform interventions and better meet group members' needs, (b) conducting outreach to strengthen community ties, enhance recruitment, and establish positive, ongoing relations with community stakeholders to ensure the sustainability of services, and (c) engaging in ongoing, critical reflection and examination of the intersecting identities, life experiences, and cultural and contextual factors. We hope that, as a collective, mental health practitioners can continue to reflect on the strengths of our existing services and areas in need of improvement in order to provide equitable and culturally salient, trauma-informed care to communities of Latina women that continue to face marginalization, trauma, and mental health disparities.

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BRIEF REPORT

Can Zoom Increase Group Therapeutic Outcomes? A Case Study Involving Therapeutic Improvisational Theater for Veterans with Addiction and PTSD

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Zoom has exploded into the recent vacuum created by the need to socially distance in all walks of life, including for therapeutic improvisational theater for veterans in long-term residential care who have addiction and post-traumatic stress disorder. This innovative program developed by St. Joseph's Addiction and Treatment Centers was designed to explore enhanced treatment modalities that could reach this population of veterans with both honorable and less-than-honorable discharges from all branches of the military, for whom shorter stays in other programs were unsuccessful.

A pilot program begun in the spring of 2019 based on the use of a key concept of improv learning envisioned providing vets with a new cognitive framework: learning to saying "Yes, and …" to facilitate a focus on positive alternatives as a way to *consciously* build their resilience.

Patricia A. O'Gorman

The original model called for improv groups to be held at the local theater, led by their staff with experience in theater and comedic improvisation and by the center's consulting psychologist, who has experience in trauma and resilience. Group therapy was then conducted by the psychologist at the center. Early outcomes of this approach were positive. In the words of one veteran: "I had to learn patience, acceptance, how to work with others, and how to be comfortable with being uncomfortable. There were days I wanted to throw in the towel and say I'm done with it all, but in those moments of doubt and uncertainty, my greatest moments of growth and change started to manifest."

Due to precautions necessitated by COVID-19, this group was moved to a Zoom platform accessed by veterans at their residential setting on one screen and the improv facilitator and the consulting psychologist on their separate screens. Group members do a numerical check-in as they begin the improv section, and a check out after the group therapy section.

The veterans reluctantly agreed to try this approach with one stipulation: to not add new members, keeping the group at six.

The length of the group was shortened to 60 minutes, bookended with 15-minute check-ins and a 45-minute therapy group following the improv group. The results have exceeded those of the in-person format.

Since moving to the Zoom platform, there has been a 10% increase in their check-in self-rating and about a 40% increase in their check-out numbers. Checking in is now at a 5–6, and checking out at a 9–10 on a 10 point scale. Their anecdotal responses have indicated a greater sense of trust and greater intimacy despite ongoing physical and psychological challenges, which make getting themselves organized for an activity that requires a high level of energy more difficult. Their increasing comfort is leading to greater risk taking as they explore alternate solutions to their addiction and trauma, and enjoy increasing support, comfort, and freedom.

Plans are now being developed to formally research this unique program in the hope of shedding light on how the use of Zoom technology can increase the therapeutic gains with no "Zoom fatigue."

Samuel M. Hall

C. David Merkel

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Social Media News

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Secondary Traumatic Stress in First Responders

Skylee Campbell and Ta-Keisha Smith
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Secondary Traumatic Stress in First Responders

One concept that is not often discussed or taught in the process of training is the cost of caring (Figley & Ludick, 2017). "The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet" (Remen, 1996, p. 52). In the fields of medical services, law enforcement, fire response, victim assistance, and mental health, professionals are frequently exposed to traumatic events, sometimes even on a daily basis (Molnar et al., 2017). Numerous terms are used to describe this concept of witnessing other's trauma and the impact that this can have on our physical, emotional, cognitive, mental, and/or spiritual functioning (Branson, 2018). While some studies incorporate specific definitions for each of these terms, others use them interchangeably (Greinacher et al., 2019). Some of these terms include *secondary traumatic stress, compassion fatigue, and vicarious trauma* (Branson, 2018). It is essential to understand these terms, as well as the impact they can have on professionals, specifically first responders.

Skylee Campbell

Definition of Terms

The term "secondary traumatic stress" will be used for the purpose of this article as it most closely relates to first responders. Figley (1995) coined the term secondary traumatic stress and described it as the phenomenon that occurs as a result of professionals (i.e., first responders, medical personnel, etc.) being "psychologically overwhelmed by their desire to provide assistance and comfort to their observations of trauma and suffering" (Branson, 2018, p. 3). It is most often used to describe professionals who frequently are exposed to the trauma of others, but who do not develop a continuous empathetic relationship with these individuals (Branson, 2018).

While secondary traumatic stress is the focus of this article, it is important to understand the definitions of the other terms as well. *Compassion fatigue*, also coined by Figley (1995) is similar to secondary traumatic stress and is often used interchangeably, as it also focuses on the observations of trauma and desire to help those individuals (Figley, 1995; Branson, 2018). *Vicarious trauma* was coined by McCann and Pearlman (1990) and can be defined as "the unique, negative, and accumulative changes that can occur to clinicians who engage in an empathetic relationship with clients" (Branson, 2018, p.2). While this original definition has been primarily studied as it relates to mental health professionals, it has been expanded to encompass first responders, to address their frequent exposure to the traumatic experiences of others (Molnar et al., 2017).

Symptoms of Secondary Traumatic Stress

The symptoms of secondary traumatic stress are similar to those of primary trauma in that they can manifest in diverse ways and in four categories, including arousal, intrusive imagery, negative changes to cognitions, and avoidance behaviors (Branson, 2018). Some common symptoms include social isolation, negative coping skills, poor decision making, unwanted mental images, high sensitivity to trauma reminders, loss of motivation, and stress-induced medical conditions (Branson, 2018). In contrast to vicarious trauma and compassion fatigue, where symptoms develop after several exposures, it has been observed that symptoms originating in secondary traumatic stress can occur after a single exposure (Branson, 2018).

Prevalence in First Responders

First responders are frequently exposed to traumatic events as part of their daily job duties. They are continuously managing unpredictable situations that can be emotionally challenging for everyone involved (Greinacher et al., 2019). Repeatedly experiencing these events, including assisting survivors and their families, and being exposed to the dead and severely injured, can cause a high level of distress and prevent the first responder from being able to adequately adapt and cope with these situations (Greinacher et al., 2019). Although little research has been conducted, some studies have shown up to 35% of first responders being at risk of developing symptoms of secondary trauma. While first responders technically encompass law enforcement, fire fighters, and emergency paramedics, similar rates have been shown for medical and mental health professionals (Greinacher et al., 2019). Concerns of those working as first responders around potential job loss and social

desirability suggests the possibility that these rates have been underestimated (Greinacher et al., 2019).

Risk and Protective Factors

While certain fields have begun to identify risk and protective factors, there is very little research on this topic. However, some risk factors that have been identified in first responders and related fields include caseload frequency, caseload volume, and having a personal trauma history (Molnar et al., 2017). Other risk factors can include age, gender, emotional exhaustion, exposure, and substance use (Greinacher et al., 2019). Some protective factors include having social support and adequate support from supervisors (Molnar et al., 2017). Additional protective or resilience factors that have been identified include self-efficacy, internal locus of control, a cohesive organization, engagement, and mindfulness (Greinacher et al., 2019).

Ta-Keisha Smith

Treatment Recommendations and Conclusion

The treatment of first responders is something that is not often addressed outside of the forensic realm. In the forensic arena, law enforcement receives psychological services after a major shootout or a traumatic event where they begin exhibiting signs and symptoms of distress. In those instances, they are encouraged to seek psychological help. However, many do not because they fear losing their jobs. Thus, it is imperative that outside psychologists are aware of the traumas this population encounters and that they are mindful of potential apprehension. As much as therapy is warranted among first responders, there are other steps organizations can take to assist their workers, such as installing a gym at the facility, a quiet room for meditation, hiring a wellness coach, and fostering an environment of social support. As mental health professionals working with first responders, we know the ramifications of trauma can manifest in variety of ways; it is imperative to advocate for treating the whole person.

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Ta-Keisha Smith *is a 5th year doctoral student at The Chicago School of Professional Psychology in pursuit of her PsyD in clinical psychology. She is a licensed psychological associate, former applied behavioral analyst therapist and registered behavioral technician. In 2014, while working as a juvenile probation officer, working with "at risk" youth, Ta-Keisha received her master's degree in forensic psychology. Her passion for helping others led her to the field of psychology. As a doctor of clinical psychology, she plans to provide comprehensive assessments. Her philosophy is the "assessment is the first step on the journey to obtaining services."*

Textbook Review: *Trauma, Resilience, and Health Promotion in LGBT Patients: What Every Healthcare Provider Should Know*

Trauma, Resilience, and Health Promotion in LGBT Patients: What Every Healthcare Provider Should Know. Eckstrand, K.L., & Potter, J. (Eds.) Cham, Switzerland: Springer. 254 pp. $109

By Jared Boot, MA and Nadeen Majeed, MA

Trauma, Resilience, and Health Promotion in LGBT Patients: What Every Healthcare Provider Should Know addresses the complex reality of how LGBT experience heterosexism and how that affects their health. Eckstrand and Potter (2017) present an exceptional text for clinicians such as mental health professionals, medical doctors, and nurses who work with trauma and the LGBT community; it aims to develop interdisciplinary teams of trauma-informed professionals. The layout of the textbook is easy to read and includes valuable pictures and tables that help the reader navigate and further recognize crucial concepts. The editors split the book into four sections, with chapters written by multiple authors. Trauma throughout the textbook is explained in a way that a reader from any discipline can comprehend. If a reader has not worked with trauma before, they could use this text as a guide to improving the overall health and well-being of LGBT patients. The well-being of clients is enhanced because the overall aim of the text is to normalize rather than pathologize the LGBT experience.

Jared Boot

The first section of the book, "Overview of Trauma in LGBT Populations," introduces the concept of trauma and how it relates to LGBT patients. The identity of a patient is a large part of who they are, and they experience situations that cause more stress -- described through the minority stress model explained in the textbook. The authors do not assume that the reader is fully aware of everything about the minority stress model and the combination of internal and external stressors that places LGBT individuals at higher risk for health disparities. This clarity and the explicit definitions used helps make sure that everyone understands the experiences of LGBT patients in the book going forward. The biology of stress is also explained to demonstrate how the negative life experiences and resultant trauma faced by LGBT individuals cause physiological changes and trauma that make them more susceptible to mental health concerns. Due to the currently narrow definition of PTSD in the DSM-V, it could have been beneficial if the editors had reiterated throughout the text how the consequences of events the LGBT community lives through daily fall under the definition of trauma.

The second section, titled "Resilience Across the Lifespan," addresses how resilience could influence patients throughout different phases of their lives and across generations. For example, youth in the LGBT community have different experiences than people of other ages. The text describes a broader sense of being able to reach out for social support using technology, and this helps LGBT youth recognize other individuals as similar to them. Importantly, the text points out how this experience contrasts with the experience of older adults in the LGBT community. When working with older patients, it is crucial to address their unique experiences of living through another era. The "Older Adults" section is an especially beneficial chapter for younger clinicians. Younger clinicians may be unaware of the isolating impact of the unique and forgotten experience that older LGBT adults lived.

The third section of the book titled "The Resilience of Specific Populations," also addresses resilience; it outlined the resilience of sub demographics of LGBT people in the face of overwhelming adversity. It was great to see a focus on positive resilience attributes since, often, there is a tendency to focus exclusively on the negative consequences of adversity. This section of the text highlights the daunting statistics faced by transgender, gender nonconforming, LGBT people of color, LGBT migrants, LB women, and LGBT institutionalized and incarcerated populations. Nevertheless, from a feminist perspective, this section also highlights how healthcare providers can empower LGBT clients by helping them focus on their strengths that have helped them survive despite the odds. Additionally, from a positive psychology perspective, the focus on resilience can foster further post-traumatic growth for these populations.

The final section of the book was particularly useful. This section extensively focused on resources available

to LGBT patients. The resources applied to every stage of life for the LGBT patient and all aspects of their lives (e.g., safe spiritual spaces, crisis hotlines). Also, the final chapter recommended a list of organizations for LGBT clinicians, such as the Society for the Psychological Study of Sexual Orientation and Gender Identity (Division 44). These resources are vital for LGBT clinicians considering their own experiences of prejudice and discrimination (i.e., trauma). The resources are especially significant, given that they may help mitigate compassion fatigue.

Nadeen Majeed

Jared Boot, MA, TLLP *is a second-year PsyD student at the Michigan School of Psychology (MSP), studying clinical psychology. On-campus, Jared has served as a student ambassador, has held multiple board positions through the Inclusion, Diversity, and Equity Alliance (IDEA), and is the current treasurer of Psi Chi. Jared's research interests are scale development to assess stigma among emerging gender and sexual minorities and the development of cultural competency training for rural clinicians that work with transgender and gender nonconforming clients. In addition to his student affiliate status through the APA, he is the vice-chair of the World Professionals Association for Transgender Health (WPATH) Student Initiative. Jared also serves on the Health Professionals Advancing LGBTQ Equality (GLMA) Health Professionals in Training Curricular Reform Committee.*

Nadeen Majeed, MA, TLLP, *is a second-year PsyD student studying clinical psychology at the Michigan School of Psychology (MSP). Nadeen served as student ambassador at MSP, is a member of the Inclusion, Diversity, and Equity Alliance (IDEA), Chair of the Psi Chi Research Symposium, and a member of the Psi Chi Philanthropy Committee. Nadeen's research interest include trauma stewardship and children's health psychology. Nadeen is passionate about working with refugees and minimizing health disparities of minority groups. She is a student affiliate of the APA and the Trauma Psychology Division 56.*

STUDENT SPOTLIGHT

Culture-Specific Factors of Posttraumatic Outcomes in Latinas

Antonella Bariani

Individuals of Latino origin (Latinx), the fastest growing minority group within the United States (U.S.; Grieco et al., 2012), have been found to be at high risk for trauma exposure related to migration, low socioeconomic status, and residence in communities with high crime rates (Cleary et al., 2018; Llabre et al., 2017). Further, Latinx in the U.S. are at an increased likelihood of facing prejudice and discrimination – an experience that, when chronic in nature, may be traumatic and have effects that mirror posttraumatic outcomes (Nadal, 2018; Rivera et al., 2010). That said, research examining how Latinx women (Latinas) uniquely experience trauma sequalae has been limited despite evidence that Latinas differ in types of trauma exposure in comparison to Latinx men (Latinos; Llabre et al., 2017) and women of other ethnic groups (Andrews et al., 2015).

Antonella Bariani

In Latinas, trauma exposure has been associated with depression, posttraumatic stress disorder (PTSD), anxiety, and substance use (Cuevas et al., 2012; Ulibarri et al., 2015). However, findings examining posttraumatic differences between Latinas and non-Latinas have been mixed. Some studies have found that Latinas tend to endorse more severe posttraumatic symptoms, such as intrusive thoughts, dissociation, and avoidance, in comparison to White women and Latino men (Edelson et al., 2007; Hall-Clark et al., 2016). Other researchers have reported no difference across ethnicity and gender even when controlling for trauma type (see Hinton et al., 2011; Perez et al., 2010). The aim of this

article is to discuss the discrepancy in these findings through consideration of culture-specific factors, such as acculturative stress and nativity, and their relation to trauma sequalae. Particularly, this article aims to highlight the importance of within-cultural variances for Latinas, the dearth of research examining these variances, and the limitations to be addressed in future research.

Culture-Specific Factors

Latinxs are a heterogenous group comprised of individuals with diverse backgrounds, differing in country of origin, customs and cultures, and languages (Hall-Clark et. al., 2016; Nadal et al., 2014). Latinas are often treated as a homogenous group in research studies when compared to other ethnic groups, though they may differ on acculturative stress, nativity, and level of discrimination and prejudice associated with both (Sabina et al., 2012; Nadal et al., 2014). A disregard for within-group differences among Latinas, particularly in studies conducted in the U.S., may explain the discrepancy in research findings (Sabina et al., 2012; Nadal et al., 2014). Nadal and colleagues (2014) noted that within a group of Latinxs, experiences of discrimination and mental health variables may vary depending on acculturation, country of origin, skin color/physical appearance, generational status, and others – factors that are rarely accounted for in the literature. This has been further supported by studies finding that frequent experiences of identity-related discrimination, which is associated with acculturative stress, anger, anxiety, depression, and dissociation, varies depending on nativity and country of origin (Cuevas et al., 2012; Lopez, 2008),

Acculturative stress, which may vary depending on nativity status and country of origin (see Nadal et al, 2014), refers to the struggles an individual may face when adapting to a dominant culture (Berry, 2006; Schwartz et al., 2010). Indeed, acculturative stress among Latinxs is most likely the result of the intersection between identity-related discrimination and prejudice, as well as a growing sense of distance from or abandonment of one's ethnic culture (Berry, 2006; Rodriguez et al., 2002; Schwartz et al., 2010). Amongst Latinas with a history of trauma, acculturative stress is associated with depression, anxiety, chronic stress, and somatization (Cuevas et al., 2012; Zvolensky et al., 2018). In a study conducted by Cuevas and colleagues (2012), acculturation influenced the relation between trauma exposure and psychological distress in Latinas. Specifically, among Latinas with a history of trauma, the relation between trauma exposure and posttraumatic outcomes (e.g., anger, dissociation, and anxiety) was stronger for individuals who indicated a lower level of adjustment to U.S. dominant culture. Such results are in accordance with a review on racial differences in posttraumatic symptomology by Hall-Clark and colleagues (2016), which indicated that Latinxs tend to report and express their posttraumatic symptoms as somatization, anxiety, sadness, and anger. This review also found differences based on nativity, reporting that Latinx immigrants tend to express their symptoms as stress and/or fear, and are more likely to report medical problems and somatization in response to trauma in comparison to their U.S. born counterparts. Studies such as Cuevas *et al.* (2012) and Hall-Clark *et al.* (2016) suggest that acculturative stress and nativity plays an important role in the varied expression of posttraumatic symptomology. Still, more research is needed to understand how cultural-specific factors specifically impact trauma-related symptoms in Latinas.

The current understanding of the cultural complexities of posttraumatic outcomes in Latinas is restricted by studies that look at Latinxs as a whole. Of those studies that conduct within-group analyses, findings indicate that Latinas tend to endorse more severe mental health outcomes in comparison to their male counterparts (Edelson et al., 2007; Hall-Clark et al., 2016; Zvolensky et al., 2018). Further, studies have also found that both immigrant and U.S. Latinas demonstrate varied levels of acculturative stress and posttraumatic outcomes (see Cuevas et. al., 2012) which may be partly due to differing understandings, appraisals, and descriptions of symptoms between immigrants and U.S.-born individuals (Hall-Clark et al., 2016). While findings suggest the unique experiences of posttraumatic symptomology within Latinas, studies geared towards examining the nuances of these differences is limited and lack consideration for intersectionality or layered complexity and overlap of having multiple marginalized identities (Nadal et al., 2014). Attentiveness to cultural factors (e.g., nativity, country of origin, skin color, language proficiency), gender roles and expectations, and the varying levels of discrimination and acculturative stress that are interwoven with both culture and gender identity (Cuevas et al., 2012; Nadal et al., 2014) may allow for a more holistic understanding of trauma sequalae in Latinas.

Discussion

There is growing evidence in the research which indicates that acculturative stress and nativity are vital facets of the Latina experience within the U.S. that may have unique effects on the relationship between trauma exposure and posttraumatic symptoms. That said, research examining how acculturative stress in Latinas impacts trauma-related symptoms is still lacking. Particularly, due to the high variance amongst Latinas across a number of variables, it is difficult to draw conclusions from studies that do not account for culture-specific factors. This, in part, has contributed to the mixed findings with respect to how Latinas experience trauma sequalae. More research is needed to understand how Latinas, in particular, experience trauma within

the context of their intersecting cultural identities. Currently, our understanding is limited to findings from studies that focus solely on one of these culture-specific factors at a time. Future research should carefully address these issues through appropriate sampling efforts of Latinas, both immigrants and U.S.-born individuals, and with the utilization of valid measures in English and Spanish that adequately capture the myriad of experiences of Latinas. Research pertaining to culture-specific factors is needed to extend the current state of the literature examining Latina survivors of trauma and to allow for better clinical understanding and consideration of different experiences related to race and cultural identity that may further compound traumatic experiences.

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International Committee Report

Elizabeth Carll, PhD

As part of the series of interviews conducted by student members with trauma psychologists from various parts of the world, **Christina Silvera**, a recently graduated student member of the International Committee, interviewed **Dr. Jhodi Bowie**, a counselling psychologist and lecturer at the University of the West Indies (UWI), Mona Campus, Department of Sociology, Psychology and Social Work.

The interview series, featuring distinguished trauma psychologists from around the world, provides our students with the opportunity to meet psychologist role models from many cultures. The interview, which follows below, provides a window into the work of trauma psychologists globally and enables a better understanding of cultural issues relating to psychology.

Elizabeth Carll

To encourage participation of international students at the APA convention, the Division approved an annual **$1000 Student Travel Stipend** including convention registration to support the travel of a student from a developing country who has a trauma-related poster or paper accepted at the convention. Unfortunately, the 2020 APA Convention which was to take place in Washington, DC has been cancelled due to the coronavirus outbreak. Events will be taking place virtually. As a result, I have recommended that the travel stipend be rolled over to next year. This would enable two students to receive a travel stipend next year for the 2021 APA Convention in San Diego. Interested candidates for the travel stipend should contact me at ecarll@optonline.net.

The Home Study on demand option for webinars has been finalized by the Webinar Committee and the past webinars of the Refugee Mental Health Resource Network (RMHRN), an APA Interdivisional project, will be available with the option for CE. The 17th free webinar of the RMHRN is scheduled for June 19, 2020 and focuses on telehealth, use of interpreters, and cultural responsiveness when working with refugees, immigrants, and IDPs.

An International Committee Interview with Jhodi Bowie, PhD

By Christina Silvera, MS

Dr. Jhodi Bowie is a Jamaican counselling psychologist and lecturer at the University of the West Indies (UWI), Mona Campus, Department of Sociology, Psychology and Social Work. She has specific expertise in traumatology and her research interests focus on women's experiences of sexual trauma, gender discrimination, and racial discrimination. She has been awarded the Margaret McNamara Education Grant and the International Peace Scholarship for her role in empowering women and children and her commitment to leadership and psychology, respectively.

After completing her Master's Degree in Clinical Mental Health Counselling at Clemson University in South Carolina, Dr. Bowie returned to Jamaica to volunteer and eventually work for the Victim Services Division in the Ministry of Justice. She went on to complete her PhD in Counselling Psychology at Georgia State University in Atlanta. She recently returned to Jamaica to work in private practice and teach at the UWI.

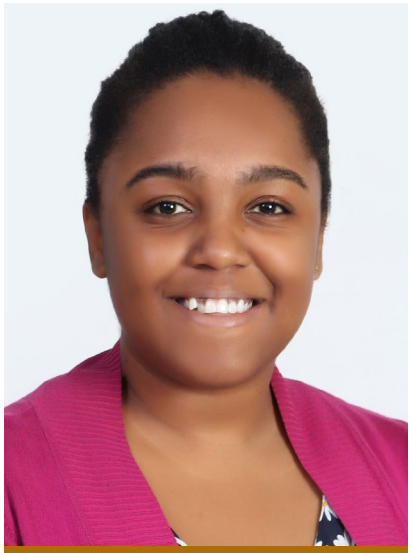
Dr. Bowie became interested in trauma during a practicum experience in her master's program, when she was assigned to Julie Valentine Centre, a rape crisis centre that focused on providing care to children who have been abused. "*I did not experience the same dread that others shared when talking about working in trauma. I found myself feeling fulfilled in the work that I was doing with clients.*" From this experience, she learned how women have difficulty when there was no use of a weapon or when they did not fight back during the rape. This sparked a new research interest into why people feel more guilt or shame in these scenarios. These experiences were the foundation of her interest in trauma, which influenced her decision to work for the Victim Services Division on her return to Jamaica. The Victim Services Division caters to children and women who are physically and sexually abused, as well as primary and secondary victims of horrific crimes. These experiences influenced the pursuit of her PhD in Counselling Psychology.

Besides trauma, Dr. Bowie has a profound interest in discrimination, particularly, gender discrimination and sexual orientation discrimination. "*In research and in my experience, I have found that trauma and discrimination are closely intertwined. It has been found that any population that has been marginalized is at high risk of violence. Women and members of the LGBTQ community face a range of acts against them from microaggressions to violent acts, which are all traumatic in some way.*" Her experiences working with women, children and the LGBTQ community has prompted her research

with sexual minority women, resilience, racial minority women and rape myth acceptance. She hopes to further her research portfolio in race and gender discrimination, psychotherapy and sexual assault victims, PTSD and suicidal ideation in women and women's health.

When asked about cultural differences in the approach to trauma between Jamaica and the United States, Dr. Bowie explained that the countries are very different, and similarities are more apparent in low income communities in the USA. She said that in Jamaica, one of the major hurdles, is the minimization of trauma and its symptoms. Due to the constant bombardment of traumatic experiences, especially since childhood, it may be a way to protect themselves from having to reflect on these painful experiences. She described how many Jamaicans do not classify their experiences as traumatic and they minimize the experiences of others, which significantly impacts their help seeking behaviors. Many times, people only seek help during extreme circumstances like psychosis or other life/death scenarios. From a systemic perspective, in the USA, information is more readily disseminated and available, and help is more accessible. "*Jamaica's response to mental health and trauma is very similar to low income communities in the USA and so we see similar statistics in our research and symptoms and attitudes in practice.*"

Jhodi Bowie



Christina Silvera

Regarding the access to tools and training in traumatology, Dr. Bowie believes that the USA has a more comprehensive method to trauma training, which she posits may be due to the wide range of trauma specialists that live in the USA. "*I had access to courses and classes in crisis management and traumatology. In the USA, there is also more access to other kinds of modalities like Dialectical Behavior Therapy training, as well as a much wider expanse of training materials and psychological modalities.*" She also said that while Jamaica has embodied the comprehensive approach to health, where there are several professionals who are engaged in the well-being of clients/patients, the country's resources limit the amount of work that can be done. Limited hospital space allows for only the most severe mentally ill individuals to be hospitalized, as well as limited staff.

Additionally, Dr. Bowie emphasized that the types of traumatic experiences that people face in both countries are very similar. "*People experience significant amounts of abuse in childhood that is covered up or not addressed and then they will resurface in adulthood. In Jamaica you will see and hear about community violence exposure, like many communities in the USA.*" She added that, the rate of domestic violence and other forms of traumatic experiences is also very similar between the two. In Jamaica, there are more reports of physical abuse of children which are disguised as punishment and then normalized among the citizens.

As a lecturer at the UWI, Dr. Bowie uses her experiences and knowledge from the USA and Jamaica to supervise MSc. Clinical Psychology Students. She says that students respond in two distinct ways to trauma. "*There are some that are very timid and want to avoid talking about or engaging with clients who have experienced trauma and there are those who want to dive right in and address it with the six sessions that they have. Despite faculty's diligent screening of clients, so that we do not expose the students to clients with significant traumatic experiences*". She has found that the minimization of client past trauma usually surfaces after students have engaged with the clients. Faculty's goal then is to help students to create a balance between the work they can realistically do in the time they have and curiosity and compassion for clients.

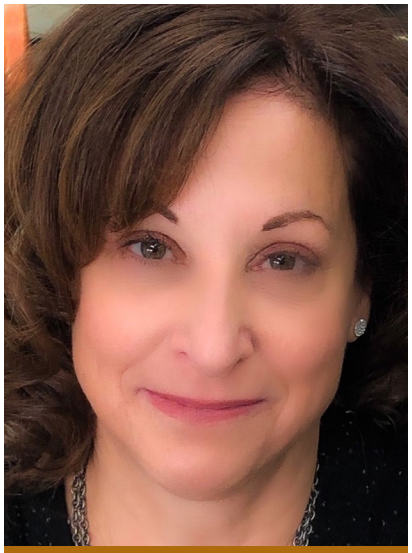
Dr. Bowie encourages all aspiring psychologists with an interest in studying or working in trauma to read current and relevant books and research related to trauma. She highly recommends, *Trauma and Recovery* by Judith Herman, *Not Trauma Alone* by Steve Gold and *Principles of Trauma Therapy* by Catherine Scott and John Brier.

***Christina Silvera** is an Associate Clinical Psychologist. She obtained her BSc. in Psychology and recently graduated with her MSc. in Clinical Psychology from the University of the West Indies, Mona. She is the Student Representative of the Jamaica Psychological Society. She has presented her findings on female friendships at the 2019 APA Annual Convention and findings on transactional sex and risky sexual practices of Jamaicans at the 2019 Jamaica Ministry of Health and Wellness Research Conference.*

Proximity to Impact

Lisa Y. Livshin

The world is up-ended. As psychologists, we would say that the world is dysregulated now. Emotional dysregulation is when people are unable to control or regulate their emotional reactions to "provocative stimuli". A pandemic is the most provocative stimulus we've ever seen. With a specialization in disaster work, I observe my own difficulty self-regulating right now. I find myself tearing up out of nowhere, experiencing unfamiliar anxiety, and wondering if I have COVID-19 every time I feel a tickle in my throat. This is a collective, national trauma in the making and I am again, one of those affected. Just like with 9-11 and the Boston Marathon Bombing - I am no longer the removed disaster psychologist looking in from the outside. Proximity to Impact is a factor we consider when assessing potential trauma. We are all at Ground Zero.



Lisa Y. Livshin

Critical Incident responders break disasters down in to phases. During the Pre-Impact phase we receive some advanced notice about the impending disaster. Last week when the pandemic was announced, we entered this phase. For me, it was time to do safety planning and gather resources just like I had always taught others to do. As I mobilized, I knew these tasks were integral to the Pre-Impact phase. Mundane errands like ordering food, wiping down surfaces, and doing an inventory of supplies, gave me a sense of agency. This is what these behaviors are supposed to provide in this phase. Like so many others, accessing medications for my family, diapers for my granddaughter and other provisions, gave me a sense of control in an out of control situation. I did this while tearing up - thinking about all the people without resources to obtain adequate supplies. I felt gratitude in a new way.

A few days passed and I realized that what I thought was the Pre-Impact phase had already become the Impact Phase.

COVID-19 had entered the United States and the science of contagion was in full force. A staggering number of people were still not fully comprehending the gravity of the virus. Those of us who understand what it means to flatten the curve, were shocked by images of college students frolicking on beaches during spring break.

This is not unusual behavior in large scale disasters. People may minimize the situation or enter a state of denial because current reality is overwhelming. They may become numb and shut down in a crisis. Many need to deflect authority and have the "no one's going to tell me what to do" mentality.

Having a president who minimizes our collective crisis has made the national denial worse. It's prevented people from mobilizing when lives depended on it.

Already I see the breaches in families when members differ on how to remain healthy. It's in my own house as my daughter and son-in-law disagree over deciding what their 2 year old can touch on walks. My relative is a therapist who is upset with me right now. I told her how irresponsible I thought she was for continuing to see patients in her home office. Lesson learned—I cannot be a disaster worker to family and friends who don't ask for my input. It can be difficult to remain mute when I know from my work that people's mental health may be impacted by how they respond during the disaster impact phase. How we behave emotionally, cognitively, and behaviorally during this stage, will affect our post-impact functioning and long-term recovery.

Today life is feeling surreal to this disaster psychologist. Throughout the day, I hear the news, check my supplies again, and tear up, as I come to understand that the Reconstruction Phase is looking further and further away.

Who's Who: Annett Lotzin, Ph.D.

1) What is your current occupation?

I am a research fellow in the Trauma and Stress Research group at the Department of Psychiatry and Psychotherapy at the University of Hamburg, and at Centra, the Refugee Coordination Centre of Hamburg in Germany. At the University Medical Center Hamburg-Eppendorf and at the Medical School Hamburg, I am a lecturer in the field of Clinical Psychology. I also work as a Clinical Psychologist with patients with posttraumatic stress disorders (PTSD).

Annett Lotzin

2) Where were you educated?

I studied Psychology at the University of Hamburg, and then worked as a research fellow at the University of Münster, Germany. Afterwards, I completed my PhD at the Department of Child and Youth Psychiatry and Psychotherapy at the University Medical Center Hamburg-Eppendorf. I conducted a postgraduate Master in Psychotherapy Research at the University of Bern, Switzerland, a five-year training as a Clinical Psychologist and a specialized training for PTSD treatment.

3) Why did you choose this field?

I became interested in traumatic stress research during my PhD. During that time, I examined difficulties in emotion regulation in mentally ill mothers and the impact of these difficulties on the interaction between these mothers and their infants. Many of these mothers were exposed to domestic violence, and the adverse mental health consequences of abuse and neglect were apparent in the third generation - the infants that I observed in the lab. Due to my increased interest in the consequences of traumatic stress, I joined the Trauma and Stress Research Group at the Department of Psychiatry and Psychotherapy. Since then I have led several research projects with patients with PTSD. The knowledge I gain in clinical work with patients flows directly into my scientific work, and vice versa. I find it fascinating to see how resilient people can be despite severe distress and how much they can often benefit from trauma-focused interventions.

4) What is most rewarding about this work for you?

I find it rewarding when my research or clinical work can have a positive impact on people's lives. The results of the randomized controlled trials on PTSD treatments that I have conducted in recent years may encourage the selection of effective treatments that can significantly improve people's quality of life. The recommendations of the treatment guidelines for PTSD, on which I worked in Germany, have to potential to improve health care by supporting health care professionals to choose to offer effective treatments.

5) What is most frustrating about your work?

My research and clinical interests concern particularly vulnerable groups with PTSD, including patients with comorbid addiction or refugees. While I enjoy working with these groups, it can be difficult to accept that only a small subgroup of those in need of trauma-specific treatment actually receive it, while most patients are not reached by the health care system or have to wait months for treatment.

6) How do you keep your life in balance (i.e., what are your hobbies)?

I enjoy dancing, which I usually do every day. This is a perfect way for me to switch off after a working day, stay physically and mentally active, and socialize. I also like running, reading, and spending time with my love ones.

7) What are your future plans?

I will pursue my research in the area of posttraumatic mental health. In particular, I hope that I can contribute to a better understanding of Complex PTSD and its treatment. I also want to further explore how treatments need to be changed so people actually enjoy using them.

She said she can't breathe

Dr. Paula MacIan

no more pee
on the toilet
she'll leave the seat up
to mark the day
that will never
end

she'll leave his socks
on the floor
his bed unmade
his bear on his pillow
waiting
for him to bound
through the door
flop on the bed
headphones blaring.

He didn't leave a note.

Paula MacIan

Dr. Paula MacIan *is a clinical psychologist licensed in Oklahoma, New Mexico and California who specializes in the treatment of trauma. Dr. MacIan has worked both in rural areas, such as the bush in Alaska for CPS, and in a large metropolitan city in the south, at a CAC. She specializes in treating children and families who have experienced sexual abuse. After working in agencies for a decade she began a private practice. She has worked with the Red Cross volunteering at disaster sites, and more recently with first responders at retreats designed specifically for them.*

Understanding Transgenerational Trauma in 2020

Lisseth London, MSW, CCTS-S, CATP, CFTP

Moment by moment I am constantly overwhelmed by the images of death, injustice, and pain.
I thought I understood what trauma was but now I am faced with an anger that floods me showing me the wound of my people.
I sit here and ponder my next move; should I scream, cry, or give up?
The world is telling me that I must understand that this too shall pass if we come together as one.
How will that help if my past is not acknowledged, my present is in jeopardy, and my future is not guaranteed?
All I want is to hug a loved one and feel the connection that has been replaced by virtual unmerited love due to Covid-19.
As one who feels persecuted, unheard, unloved, and unwanted I share my pain because I know I am not alone.
I must remember that our trauma connects us, but our hope empowers us to see beyond today and not give up on 2020 just yet.

Lisseth London *is currently a doctoral student at The Chicago School of Professional Psychology in Chicago, Illinois where she is enrolled in the International Psychology program. As an afro-Latina born in Panama City, Panama, her acculturation journey within the United States empowered her to pursue both a bachelor's and master's degree in social work. As her understanding of trauma increased, she grasped the importance of obtaining a doctoral degree dedicated to highlighting the international lens in trauma services and the benefits of a holistic approach.*

Lisseth London

Carl Shubs Photography

Good Mother - Bad Mother
This photograph captures the split between Good Mother and Bad Mother, or in the language of SAO/TEND (Traumatic Experiences of Normal Development) GEM (Good Enough Mother) and PO (Predator Other). Notably, as is the case in such splits, each image is a representation of the Infant's different *experiences* with the same person, and both images derive from the same image capture, i.e., the image on the right comes from the image on the left.

Beachfront
Captured in camera. No Photoshop compositing. This photograph captures the invisibility of the have-nots in the land of the haves.

Grauman's-Mann's-TCL Chinese Theater Late Saturday Afternoon, Sans People - Coronavirus Edition
Captured in camera. No Photoshop compositing. This landmark and historic site is typically without barricades and jammed with people: colorful street performers such as The Joker, Batman, Superman, Spiderman, and Michael Jackson, as well as tourists and locals out for a day's entertainment. But this is the time of the coronavirus pandemic. The streets are mostly empty, and this is rush hour!

Caution: Reality Ahead:
Captured in camera. No Photoshop compositing. This photograph captures the challenges (the hopes and fears) facing anyone who enters therapy. The "good news" is the abandoning of outdated scripts, irrational thinking, and dysfunctional behaviors, and the "bad news" is only bad because of the growth pains involved in the process of change.

Self Portrait 7
This photograph captures the experience of a person in turmoil, hiding from himself and the world. At some point in our lives, we have all felt like this for one reason or another. It is this commonality of experience that can enable therapists to relate to our patients and the traumatic experiences of their lives.

Love and Social Isolation - Coronavirus Edition
Captured in camera. No Photoshop compositing. The mural reads "Love: Together we Foster," or "Together We Foster Love." Yet the parking lot is almost empty. The virus has significantly impacted the love that yields fostering and the togetherness that fosters love, and we miss both. We feel the emptiness that results and that this image portrays.

Rose in Rage
This photo is an expressionistic portrayal of the emotional intensity of a person in rage, as well as possibly the experience of a person who is subjected to that rage.

Social Isolation #1 - Coronavirus Edition
Captured in camera. No Photoshop compositing. Found at the beginning of our social isolation and sheltering at home in response to the coronavirus pandemic.

Carl H. Shubs, Ph.D. *is a psychologist in private practice in Beverly Hills, California, integrating psychoanalytic and somatic psychotherapy. For over 30 years, he has helped people who are victims of violent crimes and other traumatic experiences. In doing so, he also developed specialties in anxiety, depression, addictions (substances and behaviors), LGBT issues, and infidelities. In addition, he is a contemporary fine art photographer, whose work captures the moments that surround us and that we often overlook in the mundane of everyday living. His photographs have been exhibited both nationally and internationally.*

Carl H. Shubs

Self-Care for You and Yours: CONNECT

Barbara G. Melamed, Ph.D. ABPP

We are never alone… but we must pay greater attention to the people we love… and even those around us who don't look like us, pray like us, or speak like us… they too deserve tolerance and gratitude. Watch the ZEN pig with your children or grandkids. Maybe it is we grown-ups that have a lesson to learn. It's not about wealth. It is about how we spend our **time...** not our $$$.

Barbara G. Melamed

GRATITUDE and TOLERANCE. Remember we all bleed red blood. No more wars. The message of the VIRUS is to be Virtue US… work at being united instead of declaring and fearing our differences. Embrace them instead. We must build a new foundation... Let us all remember that we need to CONNECT. Yes, some of us are ready to give our lives to help others survive. But we are all of value and we need to remember that sleep, exercise, prayer, even helping wash the dishes…will pay off in dividends.

So, there is a scientific literature as psychologists we all need to espouse. Poor health and potential PTSD is related to our anxiety, stress, and loneliness.[1] Therefore, the best way to help ourselves is to help others and stay Connected3 whether through Facetime, iPads or Jitterbug phones. Help our kupuna (elders in Hawaiian) live through the storms. No one deserves to die by themselves. The New York Times (Sunday, May 17, 2020) quoted Dr. Mark Rosenberg:" There is a wave of depression, letdown, true PTSD and a feeling of not caring anymore that is coming." Psychologists, let us step up and prove him wrong.

Camus wrote in "The Plague" (1947), describing how pandemic quarantine felt like people were "sleepwalkers" … who find heightened emotions of the first weeks devolving into despondency and detachment ...a shared sense of isolation vying with a sense of injustice… as the poor, Black, Hispanic and other minorities without access to good health care are dying in greater numbers.

Get out 3 pictures… not virtually, if you still had a camera, smell it, view her/him/them and say three things you will always remember about the people and the event. Remember too the solidarity we saw in the aftermath of 9/111 Those individuals at risk for depression and trauma-related memories at Mercy College, a Hispanic Serving University, who reported a positive active coping strategy following the Twin Towers devastation, were more likely two years later to go on with their education, jobs and family.

Thomas Di Grazia, sees COVID-19 as an opportunity for reflection and more focused mindfulness—issues such as economic inequality among people, addressing the climate crisis, fashioning a more environmentally sensitive world, gender inequality, our nation's slave past and present lingering racism, gun violence, immigration justice and correctional reform, homelessness, medical health (insurance) insecurity, and existentially for us humans…our inability to realize and become *Un Solo Popolo,* or All One People--connected together in time and apace, as we zoom through our Universe with our rendezvous with destiny. …the hallmark of human survival through the eons—human connection and reciprocal kindness... We Shall Overcome—**together.** Connect.

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The Impact of the COVID-19 Pandemic on Grieving

Rita M. Rivera, B.S. & Denise Carballea, B.A.

The world is experiencing a communal sense of grief. Individuals across the globe have lost family members, friends, and loved ones to the novel coronavirus. Moreover, sanitary regulations and health practices enforced by different organizational authorities and governments are interrupting individuals' bereavement process. Many cultures can no longer perform rituals and celebrations due to the strict policies of disposing of or cremating the bodies of COVID-19 patients. This may not only be interrupting people's grieving process but also exacerbating mental health issues, such as depression and anxiety. Bereavement is a difficult transition and process on its own. However, the COVID-19 pandemic may be transforming grief into a collective traumatic experience.

Rita M Rivera

Frontline workers, such as doctors, nurses, and medical personnel, have been exposed to a continuous pattern of death since the onset of the pandemic. These individuals have observed the loss of thousands of patients and, in many cases, frontline workers are the only people allowed to be with coronavirus patients during their final moments. In addition to this, the social process of grief is interrupted when family members and loved ones are unable to comfort or care for the patients. This inability to say goodbye can also give rise to distress, grief, anxiety, and guilt. These are all conditions that can lead to depression and post-traumatic stress disorder (Lannen et al., 2008).

Denise Carballea

Furthermore, the cultural identity of many individuals is attached to traditions and rituals performed in honor of the deaths of their loved ones. Social distancing regulations prevent families from coming together and comforting each other. In many countries, such as Honduras, traditional funerals are not allowed. Health care professionals relocate and bury bodies in order to avoid transmission of the coronavirus. In other places, ceremonies such as wakes have been conducted remotely via phone or video calls. What was once considered sacred and essential elements of the grieving process have now been substituted with virtual experiences.

Burial ceremonies and traditions can have a therapeutic effect on individuals. Research has shown that these rituals can help people cope with the death of a loved one (Bosley & Cook, 2008; Mitima-Verloop et al., 2019). For many individuals, these events are the only opportunity to bid farewell to their loved ones, as well as an occasion to receive social support for a shared loss with family and friends. Nonetheless, amidst the coronavirus pandemic, many individuals have found themselves socially isolated and grieving through a computer or phone screen. These non-traditional grieving practices may have a detrimental impact on mental health.

For thousands of individuals across the world, the COVID-19 pandemic has not only taken the life of their loved ones, but also interrupted and radically transformed their grieving process. Bereavement is a normal human experience and a natural stage of human development. The novel coronavirus may be transforming what is usually a cathartic process into a traumatic experience for thousands worldwide. In the midst of the COVID-19 pandemic, the grieving process is ever-evolving, posing many questions on how the world's communal sense of grief has and will continue to be impacted.

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Rita Michelle Rivera *is currently pursuing a Doctorate in Clinical Psychology at Albizu University in Florida. She is a Student Representative for the Florida Psychological Association-Division of Graduate Students, President of the Student Council at Albizu University,*

and Student Ambassador for APA Division 15 and APA Division 49. Rita is originally from San Pedro Sula, Honduras. Growing up in what is considered one of the most violent cities in the world, Rita became interested in psychology as she observed the impact of violence on mental health. Her current research is focused on psychoneuroendocrinology, depression, and Hispanic populations.

***Denise Carballea** is pursuing her Doctorate in Clinical Psychology with a concentration in Neuropsychology at Albizu University in Miami, Florida. She is currently the President of the Neuropsychology Club, Vice President of the Students Advocate for Youth Club, and Vice President of the Student Council at Albizu University. The majority of her clinical experience has been focused on working with individuals with cognitive impairments following a brain injury. Her primary areas of research include traumatic brain injuries (TBIs) and Alzheimer's disease (AD). Professionally, Denise is interested in contributing to the field in areas involving rehabilitation.*

New Book Announcement: *Traumatic Experiences of Normal Development*

Carl H. Shubbs, PhD

I am excited to tell you that I have written a new book about trauma: *Traumatic Experiences of Normal Development: An Intersubjective, Object Relations Listening Perspective on Self, Attachment, Trauma, and Reality,* published by Routledge and released in March, 2020. It presents a psychoanalytic perspective on trauma entailing a reconstruction of object relations, an integration with relational and intersubjective approaches, and their intersection with a redefinition of trauma, as well as a recognition of how those experiences manifest in the body. It addresses traumas of all kinds, examines how those experiences have roots in normal development, and how they are significant factors in the development and persistence of such things as addictions and eating disorders.

Though not specifically geared towards our coronavirus pandemic, it is very relevant, as it addresses our understanding of crisis, trauma, and the relationships between present and past experiences. It presents a frame of reference, a listening stance, that helps us to understand more deeply the roots of how individuals uniquely process the events they are confronted with and how we can be more effective in helping them.

Description, from back cover of the book

Traditionally, trauma has been defined as negatively impacting external events, with resulting damage. This book puts forth an entirely different thesis: trauma is universal, occurring under even the best of circumstances and unavoidably sculpting the very building blocks of character structure.

In *Traumatic Experiences of Normal Development,* Dr. Carl Shubs depathologizes the experience of trauma by presenting a listening perspective which helps recognize the presence and effects of traumatic experiences of normal development (TEND) by using a reconstruction of object relations theory. This outlook redefines trauma as the breach in intrapsychic organization of Self, Affect, and Other (SAO), the three components of object relations units, which combine to form intricate and changeable constellations that are no less than the total experience of living in any given moment. Bridging the gap between the trauma and analytic communities, as well as integrating intrapsychic and relational frameworks, the SAO/ TEND perspective provides a trauma-based band of attunement for attending to all relational encounters including those occurring in therapy.

Though targeted to mental health professionals, this book will help enable therapists and sophisticated lay readers alike to recognize the impact of relational encounters, providing new tools to understand the traumas we have experienced and to minimize the hold they have on us.

Reviews

Lawrence E. Hedges, Ph.D., Psy.D., ABPP, Listening Perspectives Study Center, Founder and Director, and author of numerous books on psychoanalysis.

> Carl Shubs has done it again! In his prior writings on transference and countertransference with trauma victims, using somatic therapies as well as psychoanalytic psychotherapy, Shubs has demonstrated a remarkable capacity to stand in many theoretical and clinical worlds at once. His unique gift is to understand and be able to effectively integrate in highly original ways numerous schools of psychoanalytic thinking as well as neuropsychological studies, infant research, and somatic psychotherapy practices.
>
> In this tour de force through the complex world of developmental, neuropsychological, and trauma studies, Shubs makes clear that all of the features described in pathological trauma situations are also to one degree or another a part of normal development.

Robert Hilton, Ph.D., Co-founder of the Southern California Institute for Bioenergetic Analysis (SCIBA) and Trainer Emeritus of the International Institute for Bioenergetic Analysis (IIBA).

> In this volume, *Traumatic Experiences of Normal Development,* Dr. Shubs has produced an encyclopedic work on the title subject. He brings to the task his understanding that comes from his clinical experience of working for decades with victims of violent crimes. In addition, he provides, in their own words, the personal theories and interpretations of the leading authorities in the field.
>
> His research comes from a personal, theoretical, and experiential base. This is no more evidenced than in a poem he wrote, "To Be in a Closet," which he inserts at the beginning of his work, where he says, "The final version [of the poem] grew out of my self-awareness regarding my own array of closets and my knowing that each of us has them."

This book is an invaluable resource for anyone working with the impact of traumatic experience on their clients or themselves.

The book is now available in print and as e-book on the Routledge site, https://www.routledge.com/Traumatic-Experiences-of-Normal-Development-An-Intersubjective-Object/Shubs/p/book/9780367429188, on Amazon, https://www.amazon.com/Traumatic-Experiences-Normal-Development-Intersubjective-dp- 0367429187/dp/0367429187/ref=mt_paperback?_encoding=UTF8&me=&qid=1582966509, and at other fine bookstores.

Please feel free to share the links and do ask your institutions and/or your library to order the book.

Carl H. Shubs, Ph.D. *is a psychologist in private practice in Beverly Hills, California, integrating psychoanalytic and somatic psychotherapy. For over 30 years, he has worked with victims of violent crimes and other traumatic experiences. His reconstructed psychoanalytic perspective explains how trauma is inherent in normal development and how we can address it. He also developed specialties in anxiety, depression, addictions (substances and behaviors), LGBT issues, and infidelities.*

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.

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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

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American Psychological Association Division of Trauma Psychology
Division 56

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Student Affairs Committee
Ayli Carrero Pinedo, BS, MS, Chair (Term Ends 12/31/21)
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Ann Chu, Ph.D. (Term Ends 12/31/20)
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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.

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PUBLICATION SCHEDULE

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

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