International Association for Resilience and Trauma Counseling

TOGETHER WE THRIVE!

MISSION

To enhance the quality of life for people and communities worldwide by promoting the development of professional counselors, advancing ACA, the counseling profession, and the ethical practice of counseling through trauma-informed practices, respect for human dignity, cultural inclusivity, and resilience.

DIVERSITY STATEMENT

IARTC is committed to Diversity, Equity, Inclusion, Understanding, and Empathy. We work to promote ethnic and racial empathy and understanding. IARTC continues to advocate, advance, and improve educational, professional, and leadership opportunities for members from diverse cultural backgrounds. IARTC denounces all forms of racism.

THE OFFICIAL NEWSLETTER OF IARTC

EDITED BY DRS. TAMARINE FOREMAN, K.LYNN PIERCE & CHARMAYNE ADAMS

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IARTC JANUARY NEWSLETTER

In this issue:

GREETINGS IARTC MEMBERS & OTHER CURIOUS READERS

Dr. Lisa López Levers, PhD, LPCC-S, CRCC, NCC

It is my distinct honor to write this first column, as the new 2023-2024 International Association for Resilience and Trauma Counseling President! I'd like to share a few of the major reasons why I feel so honored, but before I proceed, I'd like to tell you all how incredible you are! YOU, the members of IARTC, have made this all happen. To paraphrase Freddie Mercury's iconic anthem slightly, "YOU are the Champions, my friends!" YOU moved IARTC from stardust through the Big Bang, at warp speed! You truly are amazing, and it has been a joy to watch this unfold! So now that I've used way more exclamation points, in one paragraph, than any English teacher would permit, let me share those reasons.

First, the reality that we have been able to give birth to this marvelously dynamic new Association is stunning! The need for a trauma-focused Association has been apparent for decades, and a lot of dedicated counselors have been working hard, over the years, to bring this idea to fruition. Counselors long have been assisting clients to deal with the effects of psychosocial trauma and to build greater resilience in their lives. We are grateful that, on 24 March 2022, the ACA Governing Council approved the International Association for Resilience and Trauma Counseling as an ACA Division. I am profoundly honored to serve as IARTC's third president, humbly following in the extraordinary leadership footsteps of IARTC's first and second Presidents, Dr. Carol M. Smith and Dr. Peggy Mayfield, respectively, and continuing to pave the way for the astute leadership of our President-Elect, Dr. Matthew J. Walsh.

Second, I feel greatly honored to serve the membership of IARTC. Meeting many of the Association members, whether in person or virtually, has been inspiring to me. IARTC members have shown the fortitude and professional resilience to make an enterprise like this happen. It is beyond belief that we have been able to organize and mobilize efforts so as to build a professional Association that, in less than two years, has a membership roster of over 1,500 and continues to grow. We have functioning committees, with vibrant and energetic leaders and members, who have begun to construct important aspects of our growing infrastructure. This quarterly newsletter, the quality of which is more akin to a professional magazine, is in its 5th edition of publication. Several months ago, IARTC's peer-reviewed academic journal launched an initial call for manuscripts. Perhaps most importantly, the clinical services of our member-counselors are so needed in the current landscape of everything that is occurring in the world at this juncture in time. As we are growing an inclusive and robust organization, we also strive to grow a smart and strategically planned infrastructure, one that is both sturdy and nimble, with an aim to meet the needs of our constituents as deftly as possible.

Third, I feel honored by our purpose for inaugurating this resilience- and trauma-focused Association, our raison d'être: the clients whom we serve. I feel especially humbled when I consider the many people who benefit or may benefit from trauma-and-resilience-informed counseling. I have been providing trauma counseling for nearly 50 years, observing the growth in this arena, and seeing how counseling professionals continue to develop the insight and sensitivity requisite for working with people who have experienced paradigm-shifting harm. I believe that our constituents need us to have an organization like IARTC. They need us to have strength and diversity in membership, so that we can continue to support one another in growing our knowledge bases and skill sets, which we can do in the following ways: through developing a greater emphasis on resilience- and trauma-informed instruction, in graduate counseling programs; through enhanced professional training; and through encouraging and promoting perceptive and discerning resilience- and trauma-focused research.

GREETINGS FROM OUR PRESIDENT (CONTINUED)

Dr. Lisa López Levers, PhD, LPCC-S, CRCC, NCC

Finally, I feel honored that, by forming and serving an organization like IARTC, we collectively are rising to meet the needs of the epoch in which we live, a zeitgeist marked both by adversity and by advantage. The theme for my presidency year is that psychosocial trauma is both a personal and a public health issue. Many people around the globe have been affected by the tragedies associated with war, conflict, interpersonal violence, pandemics, natural and human-made disasters, anthropogenic climate change, and various other crises. Counselors are positioned to help individuals in dealing with related trauma, as well as to assist communities with resilience-building efforts that can aid people in making necessary adjustments to accommodate to our changing times.

As a parallel to the wise African proverb, "It takes a village to raise a child," I would like to assert that it takes a collaborative of counselors to grow a resilience-focused and trauma-informed organization. This is my call to any reader who wants to get more involved: Please let us know! A list of IARTC Committees and descriptions of their functions appear on our website, for anyone who might be interested in linking up with a committee—and despite our large and growing membership, we're still working out the nuts-and-bolts, or as our first IARTC President has been fond of saying: "We're still building the airplane while we're flying it!" (Dr. Carol M. Smith).

Our newsletter accepts articles, and our journal awaits IARTC-informed scholarship. We encourage any IARTC members, with ideas or feedback, to contact us:
President: Dr. Lisa López Levers, Ph.D., LPCC-S, LPC, CRC, NCC; levers@duq.edu
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We also encourage any other IARTC-curious readers to consider joining IARTC, now. Please know that we welcome you!

In the meantime, it truly has been my distinct honor to write this first column, as the new 2023-2024 IARTC President. I hope that I was able to offer a few ideas, and that we can work together to form a more trauma-sensitive and resilience-focused environment. And I'm still channeling Freddie: **"YOU are the champions, my friends!"**

Thank you for all that All of You Do!

Warmly,
Lisa López Levers, Ph.D., LPCC-S, LPC, CRC, NCC

ARTICLES

"There is divine beauty in learning... To learn means to accept the postulate that life did not begin at my birth. Others have been here before me, and I walk in their footsteps."
— Elie Wiesel

Cultivating Post-Traumatic Growth in Suicide Loss Survivors

By Elizabeth M. Portaluppi & Luis Montero
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The term suicide loss survivor can include family members, friends, and colleagues who have experienced psychological, physiological, or social distress for an extended period of time following the suicide of a significant other (Gilo et al., 2022; Levi-Belz, 2019). According to the World Health Organization in 2017, General Social Survey data indicated that 51% of the U.S. population knows at least one person who has died by suicide (Levi-Belz et al., 2021). Globally, it is reported that about one million people die by suicide each year, leaving millions of bereaved suicide-loss survivors (Levi-Belz, 2019).

Given the pervasive social stigmatization of suicide, it can be challenging for surviving loved ones to talk about the loss, creating a barrier for accessing needed support in the healing process (Contessa et al., 2021). The grief experienced by suicide survivors can include intensive emotions like guilt, confusion, rejection, shame, and anger leading survivors to withdraw socially and attempt to conceal the cause of death (Gilo et al., 2022; Levi-Belz, 2019). Suicide-loss survivors are more likely to experience symptoms of Major Depressive Disorder and Post-Traumatic Stress Disorder (PTSD) than those grieving a loss caused by an unexpected natural death (Contessa et al., 2021; Levi-Belz et al., 2021; Sanford et al., 2016). Family members also report difficulty communicating the pain they feel about the loss, as well as difficulty understanding the reason for the suicide (Contessa et al., 2021). Often times, suicide-loss survivors see themselves responsible for the suicide, contributing to those reported feelings of guilt and shame (Contessa et al., 2021). These survivors are also at higher risk for suicide themselves, as they experience suicidal ideation and behavior more often than other bereaved individuals (Gilo et al., 2022).

Post-Traumatic Growth

Tedeschi and Calhoun pioneered the concept of post-traumatic growth (PTG) with their seminal work on the topic in 2004 (Levi-Belz et al, 2021). Post-traumatic growth is unlike the typical growth one experiences throughout life and is defined more specifically as "a construct of positive psychological change and psychological transformation that occurs in the wake of struggling with a highly challenging, stressful, and traumatic event" (Gilo et al., 2022). Other terms such as *stress-related growth* or *personal growth* take on a similar concept in the literature (Levi-Belz et al., 2021). It is important to emphasize for trauma counselors that PTG is not an automatic or expected result of trauma, and is dependent upon an individual's pre-trauma personal, interpersonal, and cognitive characteristics (Gilo et al., 2022). It is also important to mention that researchers found demographic variables, such as age, religion, and time since the loss have been found to be correlated with higher PTG among suicide-loss survivors (Gilo et al., 2022). Self-disclosure, sense of belonging, and social support are associated with higher levels of PTG (Levi-Belz, 2019). Research also shows suicide loss survivors struggle to forgive themselves or family members who they blame for the death (Botha et al., 2009; Lee et al., 2017).

Counseling Implications

In counseling the use of adaptive coping strategies such as positive reappraisal and refocusing were found to have a positive contribution to PTG by reducing emotional distress, anxiety, anger and on the contrary lower skills in coping strategies have been linked to several mental disorders (Gilo et al., 2022).

One such strategy, self-forgiveness has been defined as the process where an individual accepts their mistakes and/or failings and searches to let go of self-anger or self-resentment, and instead focus on positive emotions, thoughts, and behaviors to better themselves (Gilo et al., 2022). Self-forgiveness has also been found to help with personal and interpersonal adaptive qualities like emotion regulation, as well as high levels of positive relationships and social support (Gilo et al., 2022). High levels of self-forgiveness were also found to be negatively correlated with symptoms of depression and suicide (Gilo et al., 2022).

Another strategy that can be used in counseling is teaching the client self-disclosure. Self-disclosure levels are shown to reduce grief and improve mental health, as well as help promote PTG among suicide-loss survivors (Gilo et al., 2022). This means that sharing painful emotions due to loss is an important part for the development of PTG because support from others helps dealing with trauma and diminishes loneliness, self-disclosure has also been shown to lower the risk of developing complicated grief, which is an ongoing, heightened state of mourning that keeps you from healing (Gilo et al., 2022).

Clinical Recommendations

Trauma therapists working with suicide loss survivors can utilize these recent research findings on post-traumatic growth to guide clinical interventions and treatment plans. It is no surprise that researchers agree on the importance for therapeutic counseling for this population, though knowing which approaches to take is not always intuitive. For this reason, we propose the following recommendations as rooted in the aforementioned studies.

First, and most obviously, individual clinical mental health counseling is recommended whenever possible for suicide loss survivors (Botha et al., 2009). Some studies understandably suggest that better outcomes can be expected when clients begin counseling shortly after the death, as opposed to several months or years later (Botha et al., 2009). The therapeutic relationship serves an important role for this population, considering the correlation between self-disclosure and post-traumatic growth (Levi-Belz, 2019). For a type of complicated grief so shrouded in stigma, the safe space of a therapist's office and nonjudgmental demeanor of an empathic counselor may enable some to share about their loss, potentially for the first time. Furthermore, therapists should consider mindfulness-based approaches that promote self-compassion and self-forgiveness to combat any misplaced self-blame or guilt that may be present (Botha et al., 2009).

Once clients are at a place in their bereavement where they can safely participate in group therapy, counselors should attempt to connect suicide loss survivors to therapeutic processing groups and peer support groups. In addition to the increased opportunity for self-disclosure, suicide loss survivors who participate in group therapy are better positioned to develop an improved sense of belonging. While isolation can worsen depressive symptoms, perceived social support is associated with higher levels of PTG (Drapeau et al., 2019). Therapists should work toward building a large support system for grieving survivors to normalize and encourage self-disclosure and improve their sense of social support and belongingness (Drapeau et al., 2019; Sanford et al., 2016).

Lastly, relationship-based approaches that address concerns within couples and families should be prioritized as research indicates many suicide loss survivors will experience relationship difficulties fol lowing the loss (Lee et al., 2017). This is in part due to the blame often present among family members after the death of child (Moore et al., 2015). Given suicide loss survivors often try to identify the reasoning behind the decision made by the deceased, those closest within the family may experience blame or resentment from other family members (Contessa et al., 2021; Moore et al., 2015). Family counseling models can help family members heal together, prevent further isolation, and help families navigate the new dynamics that follow a death of a loved one.

Cultivating Post-Traumatic Growth in Suicide Loss Survivors (References)

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Suicide Resources

American Counseling Association: Suicide Prevention & Resources
https://www.counseling.org/knowledge-center/mental-health-resources/suicide-prevention

988 Suicide and Crisis Line:
https://988lifeline.org/

International Survivors of Suicide Loss
https://afsp.org/international-survivors-of-suicide-loss-day/

Where to Begin? A Guide for Working with Bereaved Parents After Child Loss

By Ahsley Stern & Jaqueline Laurenzi

It is difficult to understand the trauma resulting from losing a child. As counselors, it can seem daunting to work with bereaved parents, as the fear of saying "the wrong thing" or worsening the situation is a realistic concern. In this article, we hope to provide a brief guide to working with this population.

According to the American Psychological Association, bereavement refers to the condition of having lost a loved one. Individuals experiencing bereavement may experience emotional pain and distress, which they may or may not express to others. It is important to note that individuals' responses to grief and their processes of mourning vary.

Parents who lose a child are a particularly vulnerable group. According to the CDC (2021) an average of 44,000 children die yearly. Approximately half of these deaths include infants up to age one. Of the remaining group, the majority of deaths are those of adolescents aged fifteen to nineteen whose primary causes of death include accidents, homicides, and suicides. In children ages five to fourteen, the leading causes of death are accidents, including deaths resulting from cancer. The smallest groups of deaths are those of children aged one to four, who mostly succumb to congenital malformations and chromosomal abnormalities.

Often, a child's death is sudden, requiring a different set of interventions and supports than typical bereavement. Guilt, shame, and stigmatization associated with sudden death can lead to an elevated risk for mental health disorders (Wagner et al., 2021). Only in very young children, where abnormalities were present from birth or where cancer developed, could parents prepare themselves to grieve. This type of grief is referred to as anticipatory grief. In this case, parents can begin coping and reorganizing before the loss, managing demands, and working towards "good death and preparedness" (Kochen et al., 2020).

Presenting Symptoms

Sudden loss creates a separate spectrum of mental health risks, including complicated grief, prolonged grief disorder, symptoms of anxiety and depression, and PTSD. Jordan (2020) explains that mourning after a suicide [or accident] differs from more normative causes of death (p. 2). In a recent study of bereaved parents, Kochen et al. (2020) found that 10-25% of grieving parents experience severe disruption to their emotional stability. Kersting et al. (2011), found a prevalence of prolonged grief of 23.6% in a population-based sample, including bereaved parents. Additionally, Goldstein et al. (2018) reported a prevalence of prolonged grief in 50% of mothers whose babies died suddenly and unexpectedly from sudden infant death syndrome (SIDS).

Prolonged Grief is characterized by intense yearning and sadness, typically accompanied by persistent thoughts or memories of the deceased and an inability to accept the reality of the loss (Prigerson et al., 2009). Rumination is common, and individuals with complicated or prolonged grief often avoid situations that remind them of the loss and withdraw from family and friends (Shear, 2015).

According to Wagner et al. (2021), symptoms of grief are most elevated in the first year after loss and typically decrease five years after the loss. Calderwood and Alberton (2023) spoke to groups of bereaved parents and determined common themes as individuals experience the grieving process, keeping in mind that these stages are not prescriptive or linear. Initially, parents describe themselves as helpless. Shortly after that, they identified feeling as if they were in a fog. About six months later, bereaved parents' emotions fluctuate from expecting normalcy to feeling disbelief. Often, this is the stage when

professional help is sought. A year after the death, parents appear 'back to normal' and report feeling more emotional strength; however, there is a strong sense of guilt around enjoying activities or not regularly thinking about the deceased. Many bereaved parents continue to rely on mental health support during this time. Three years later, many bereaved parents can enjoy themselves without guilt, have reidentified themselves, and no longer require consistent mental health support. This is often the stage where resilience begins to show. Usually, by four years after death, most bereaved parents have created a new, continuing bond with the deceased.

Assessments

When working with bereaved parents, assessments can help determine the most beneficial counseling approach. Possible assessments include a Prolonged Grief Disorder Scale, Dyadic Coping Inventory, Post-Traumatic Stress Diagnostic Scale, Beck's Depression Inventory, or a Mental Status Exam. Professionals are equipped to utilize these assessments to help determine the level of mental health concerns.

Interventions and Models

There is no prescriptive approach to working with bereaved parents. According to Jordan (2020), "A common clinical error is to immediately try to 'fix' the presenting problem with tools available to the clinician without establishing a secure relationship with the client" (p.1). A clinician's first priority is developing a trusting, supportive relationship with the client. After that, clinicians may find it helpful to use one or more therapeutic models to guide their practice.

Psychoeducational groups are an effective supplement to individual counseling. A group setting encourages individuals to verbalize their shared thoughts and experiences. They may also acquire awareness of triggers and interventions, participate in problem-solving, and find additional social support. (Berdardelli et al., 2020). Narrative Therapy is another integrative approach that has been a successful addition to therapy. According to Nelson et al., (2022), when bereaved parents write about their grief, they create an organized, coherent way to understand their trauma. Additionally, a written account allows the bereaved to share their experience with those who can support them (Hedtke, 2014).

Some models used to work with bereaved parents utilize a set of actionable steps the client and clinician can work through together toward healing. These include MCoyd's 5 V's (1987) and Kochen's five steps (2020). MCCoyd's action steps prompt the mourner to consider their emotions as valid and identify where they may find support, or lack support, for their grieving process. It also encourages the bereaved to make meaning of the loss through remembrance activities and discussion. Finally, this model includes a proactive aspect where the counselor encourages the client to consider future triggers. The counselor can also share lessons from others that may comfort or assist the bereaved. (Levers, 2022) Similarly, Kochen et al. (2020) describe how counselors can partner with their clients as they grieve. Steps include acknowledging the deceased's life and the loss of parenthood with that child, establishing keepsakes, and remembrance activities. Kochen and colleagues (2020) also include an education and information component of counseling, such as explanations of symptomology and relaxation techniques.

There is a collection of grief-specific models clinicians may wish to choose from when working with bereaved parents. One model is the Dual Process Model of Grief (Stroebe & Schut, 2010,). This model considers two types of stressors related to bereavement, processing the loss and restoration as a way to address adaptive coping.

Conclusion

Grief can manifest in a multitude of ways. As clinicians, we acknowledge that we are not

Where to Begin? A Guide for Working with Bereaved Parents After Child Loss (Conclusion and References)

responsible for fixing the situation, but we are responsible for helping the bereaved grieve and process the loss.

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From Heartbreak to Healing: Supporting Mass Shooting Survivors in Early Recovery

By Rebecca Cowan, Raven Lee, Eveyn Duran, & Sandra Mateor

Lankford and Silver (2020) define public mass shootings as incidents that result in four or more deaths. Over the last decade, the frequency of these incidents has increased (Callcut et al., 2019; Cowan et al., 2020), and they have become deadlier, with 53% of high-fatality incidents occurring between 2010 and 2019, an increase from 15% over the prior decade (Lankford & Silver, 2020). This highlights the urgent need for counselors to be prepared to support communities affected by mass shootings. However, limited information and literature are available on this topic. This article aims to provide a brief overview of how counselors can assist survivors in the initial phases of disaster recovery following a mass shooting.

Assisting Survivors During the Initial Recovery Phases

Disaster recovery involves seven phases: warning, impact, heroic, honeymoon, inventory, disillusionment, and reconstruction (to learn more about these phases, please see DeWolfe, 2000). In the initial phases of recovery following a mass shooting, survivors may not seek traditional mental health services due to the shock or lack of awareness of how to obtain these services (Cowan et al., 2020; Novotney, 2018). As a result, counselors will need to modify their approach and find alternative ways to meet the needs of survivors.

After a public mass shooting occurs, a Family Assistance Center (FAC) is commonly established within the community (U.S. Department of Justice, n.d.). The American Red Cross (ARC) and the Federal Bureau of Investigation Office for Victims of Crime (FBI OVC) typically provide initial mental health support to survivors and co-victims (family members of the deceased) and help these individuals to establish with providers in the community for ongoing care if needed (U.S. Department of Justice, n.d.-b). If counselors are interested in offering individual or group therapy, they can reach out to and partner with the ARC and FBI OVC. Counselors may also find it helpful to connect and partner with other mental health professionals and faith leaders within their community. Leveraging community partnerships and sharing resources prevents duplication of services and ultimately strengthens the overall response.

During the initial phases of disaster recovery, survivor and co-victim reactions and needs vary widely (Halpern & Vermeulen, 2017). As survivors of human-made disasters are at a greater risk of psychological distress, early interventions are essential to help mitigate long-term traumatic stress reactions (Novotney, 2018). Collective healing is critical, especially in the early phases of the recovery process. To assist with this, counselors can encourage survivors to attend community events, such as memorial services, to help build resilience and support. Counselors may also find it helpful to participate in these events to safeguard their healing and support survivors and community members. To further bolster support, counselors may find it beneficial to connect impacted individuals to "survivor's networks," such as Survivors Empowered (2023) and the Rebel's Project (2022). These networks connect survivors of mass shootings, providing peer-to-peer support and sharing of resources. Finally, counselors can familiarize themselves with programs available to survivors at later stages of their recovery, such as The Onsite Foundation's (2023) "Triumph Over Tragedy" retreat for mass shooting survivors and consider providing this information to survivors. Sharing resources for the later stages of recovery can help survivors develop a long-term care strategy.

Counselors should consider reaching out to and assisting often overlooked populations, such as first and second responders and hospital personnel (e.g.,

physicians, nurses, and respiratory therapists) who treated victims of the mass shooting (Cowan et al., 2020; Cowan et al., 2023). Due to their level of trauma exposure, these professionals are at an increased risk of developing posttraumatic stress disorder (PTSD) and often need support (Halpern & Vermeulen, 2017). One participant poignantly stated in Cowan et al.'s (2023) recent qualitative study, which explored physician experiences treating victims of mass shootings, "it's life changing…it will stay with me forever." However, despite being so profoundly impacted, the needs of these professionals frequently go unmet. Therefore, counselors might consider offering therapeutic groups for first and second responders in addition to and separate from survivors and community members.

The Substance Abuse and Mental Health Services Administration (SAMHSA) provide several resources counselors can use when working with survivors and co-victims. For instance, for individuals who are in crisis or experiencing emotional distress, SAMHSA (2022) offers a 24/7 Disaster Distress Helpline (1-800-985-5990). SAMHSA's (2022b) website also provides several handouts on mass violence that can be printed and shared with impacted individuals. Finally, The National Child Traumatic Stress Network's (n.d.) website also provides resources on mass violence, many of which are multilingual.

Prioritizing Counselor Self-Care and Preparedness

Responding to mass shootings places counselors at a higher risk of developing vicarious trauma (VT; Cowan et al., 2020). Vicarious trauma is a stress response that occurs when an individual is consistently exposed to the traumatic experiences of others and is considered a known hazard for clinicians (Molnar et al., 2017) as it can change counselors' worldviews, belief systems, and how they engage with others (Canfield, 2008). Although no studies have explored VT in counselors after working with survivors of mass shootings,studies have found VT to be prevalent among mental health and healthcare professionals when treating survivors of disasters (Pulido, 2007). It is unrealistic to expect mental health professionals to respond to such events and not be impacted (Molnar et al., 2017), and tools like the Self-Care Assessment Scale (Saakvitne & Pearlman, 1996) and the Secondary Traumatic Stress Scale can be used to measure counselor distress (Bride et al., 2004).

Increasing counselors' self-efficacy may help prevent VT, as counselors who believe they are prepared to respond to traumatic events are less likely to experience the effects of VT (Molnar et al., 2017). Therefore, familiarizing themselves with the phases of disaster recovery, disaster mental health approaches such as psychological first aid (PFA), and available resources will ready counselors for this critical task. Additionally, counselor self-care is vital, especially if the counselor resides in the impacted community, as they may be personally affected by the shooting, which places them at a greater risk of developing posttraumatic stress symptoms (PTSS). Self-care strategies may include activities such as meditation, mindfulness, and exercise and should be implemented before responding to the incident (Cowan et al., 2020).

Conclusion

Mass shootings continue to grow yearly in the United States; as a result, more counselors are treating survivors and co-victims. Counselors must prepare themselves ahead of these incidents to ensure that they guard against experiencing PTSS and VT. The more prepared counselors are, the more successful they will be in providing the necessary care to the community and themselves.

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Impact of Mandating Counseling for Emergency Medical Service Professionals

By Amanda Mohammed

Employee Assistance Programs (EAPs) are free mental health resources provided by employers to help their employees face issues such as work-related potentially traumatic events (PTEs) (Carlan & Nored, 2008). However, research by Hutchinson et al., (2021) showed despite 93% of Emergency Medical Service (EMS) professionals feeling the need for greater counseling availability, only 23% actually pursued counseling. EMS are rated the highest in posttraumatic stress injury (PTSI) induced by workplace trauma, yet many do not access their EAP due to various barriers preventing them from utilizing it (Hutchinson et al., 2021; Morganstein et al., 2017; Tucker, 2015). The silent epidemic of suicidality is rapidly increasing within EMS's branches. It has worsened to the point of death by suicide now being more prevalent than death while working in the line of duty (Geuzinge et al., 2020; Vance et al., 2021).

Carleton et al., (2019) found that exposure to a potentially traumatic event (PTEs) is more commonplace among public safety officials; however, procedural training and post-incident follow-ups do not adequately address the mental health needs of the employee (Carlan & Nored, 2008). Critical Incident Stress Debriefing (CISD) was initially created for emergency services personnel to reduce the psychological symptoms of stressful events (Levenson, 2007). Yet, there is an increasing rate of suicidality among various other mental health disorders such as PTSD, depression, alcohol/substance abuse, and intimate partner violence (Lees et al., 2019; Xu et al., 2021).

Exposure to Work-Related Potentially Traumatizing Events

EMS encompasses individuals who respond to emergencies to protect thewellbeing of citizens, including military personnel, police officers, firefighters, paramedics, dispatchers, and emergency room (ER) doctors and nurses (Ricciardelli et al., 2020). The nature of responsibilities for public workers requires them to, directly and indirectly, be exposed to PTEs. Work-related PTEs range from officer-related gun violence, rescuing victims from a burning house, witnessing the murder of a colleague or victim, or the gruesome crime scene of a victim's attack or murder (Carleton et al., 2019; Wise & Beck, 2015). Being an EMS involves constant exposure to situations that regular civilians will never face at any given point in their life (Kim et al., 2019)

The DSM-V defines a traumatic event as exposure to immediate threat at an individual's life in the form of actual or threatened death, serious injury, or sexual violence; and resulting from performing one's job duties, causes extraordinary physical, emotional, or cognitive responses (Avdija, 2014). Resultingly, symptoms such as restlessness, insomnia, anxiety, social withdrawal, hypervigilance, constant worrying, nightmares, intrusive thoughts, and flashbacks may arise, impeding regular emotional, cognitive, and behavioral functionality (Carleton et al., 2019). Mental health dysfunction can cause an increase in workplace absenteeism, poor presenteeism, task avoidance, interpersonal conflicts, decreased productivity, and loss of motivation (Kim et al., 2019).

Responsibility and Accountability by Employers

Organizations have implemented stress intervention services to help address the needs of EMS's facing posttraumatic psychopathological symptoms; however, the literature shows less than seventy-five percent of employees access it (Tucker, 2015). Barriers to counseling include lack of awareness of the service's existence, fear of stigmatization, confidentiality concerns, lack of confidence in the therapist and their ability to relate to the PTE, and perceived organizational support (POS) (Tucker, 2015; Xu et al., 2021). POS is an operational factor affecting multiple barriers such as confidence in mental health services, workplace culture of discouraging a display of negative emotions, stigmatization, and their valuing and

caring of their employee's wellbeing (Tucker, 2015).

Presently, most EAPs offer employers mandatory counseling, allowing them to mandate that their employee seek counseling for a specific number of sessions dependent on the employee's presenting issue and may refer to a higher level of care as needed (Gatchel & Schultz, 2012; Xu et al., 2021). This includes topics such as alcohol and substance abuse, interpersonal conflicts, and work-related traumatic incidents. The EAP provides an additional layer of confidentiality and privacy to EMSs thanks to outsourcing in-state/zip-code therapists (Gatchel & Schultz, 2012; Xu et al., 2021). The Americans with Disabilities Act (ADA) of 1990 protects employees from psychiatric disability discrimination by employers does not provide an operational distinction to encourage organizations to distinguish physical and mental illness, causing the burden of responsibility for work-related PTEs to rest upon the EMS's shoulders.

Wise and Beck (2015) showed that individuals who experienced a PTE saw an increase in disability-related expenses such as medical costs and treatment expenses; however, one of the most prevalent causes of work disability affecting occupational, social, and family functioning, was PTSD. Resultingly, workers compensation (WC) was enacted for employers to help with medical costs, but it requires the employee to relinquish suing rights and provides the employer with no-fault benefits. Furthermore, many WC laws were found to have loopholes that allow employers to deny WC claims causing debilitating impairment inconsistently (Wise & Beck, 2015).

Current Approaches Used to Alleviate Posttraumatic Stress Psychopathology

A plethora of empirical research supports psychological intervention for PTEs. CISD is currently the leading plan of action by organizations following exposure to PTE. CISD s a peer-driven critical incident stress management (CISM) team consisting of and supplemented with support from a CISM-trained therapist. CISD occurs in seven phases consisting of introduction (explanation and rationale provided; confidentiality reassured, fact (questioned about the perception of PTE), thought (first impression of PTE), reactions (sharing emotional responses), symptoms (gathering physiological changes during PTE), teaching (shares expectations and concerns), and lastly, the re-entry phase (summarization, potential counseling referrals) (Lees et al., 2019. However, findings show that CISD does not prevent PTSD (Bryant, 2007).

Many aspects of EMS training do not address mental health wellness, nor does it attempt to foster work environments that encourage help-seeking behaviors. However, work-related PSE is a crucial element of an EMS's job description. On the contrary, many studies show that high rates of stigmatization and internalization of trauma are running rampant in EMS's work culture. Tucker (2015) found that using therapy services outside of the organization was overwhelmingly used by EMSs, indicating a tremendous need for the service to be outsourced. Despite various educational training to help prepare an EMS for PTEs, experiencing a PTE is vastly different from learning about it. EMSs can experience distress when attempting to interpret PTEs, both logically and emotionally cognitively. For example, an EMS who watches seized child pornography as a job responsibility, containing graphic, gory acts against a minor, can trigger past traumatic events for the EMS or cause vicarious traumatization.

Operationalizing Employee Assistance Programs to Benefit Employees

Outsourcing mental health services to companies that cater to holistic wellness are beneficial and in-demand by employees. Xu et al. (2021) illustrated the significance of the EAP to help alleviate and reduce psychological stress for healthcare professionals during the coronavirus pandemic.

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The coronavirus pandemic became a PTE for EMSs such as ER paramedics, doctors, and nurses who, at times, also witnessed mass suffering and deaths that led them to feel helpless, overwhelmed, and hopeless. Mandating counseling that is outsourced to an EAP provider can increase the employee's willingness to access it while facilitating an elimination of the fear of stigmatization.

Due to the varying extent and subjectivity of workplace trauma, Ricciardelli et al. (2020) found the existence of a trauma hierarchy that further traumatizes the PSP and propagates stigma and discrimination where some PTEs may be discredited or undervalued. Furthermore, PSPs may perceive the PTE as traumatic, but suffering is not justified causing an avoidance or repression of feelings. The DSM-V now allows the inclusion of both direct and indirect exposure to a PTE as being potentially reactive in the PSP highlighting the critical need to address the mental health needs of employees. Evidence-based practices are essential in creating and implementing procedural changes to ensure companies address the appropriate needs of employees exposed to workplace trauma. Mandatory counseling for public safety officials exposed to a traumatizing workplace event can help reduce the presentation of mental health issues resulting from the stressful incident.

Implications for Practice

Given the distinctive risk embedded in the nature of a public safety profession such as police officers, paramedics, and firefighters, it is essential to normalize help-seeking attitudes for mental health care and eliminate stigma and discrimination that has been debilitating to the EMSs who are highly affected by exposure to traumatic events (Hutchinson et al., 2021). Understanding the way these professionals derive meaning from their experiences are essential in creating competent treatment plans to holistically address their mental health needs. Counselors must be cognizant of the work culture EMSs face where they can often be ridiculed and further traumatized due to seeking help. Additionally, they may fear being desked or terminated for admitting they need mental health care due to the stigma around counseling for EMS and the fact that counselors approve or deny return to work paperwork which can decrease the level of trust within the counseling relationship. Learning the cultural language and phrases that EMS use can help facilitate the therapeutic relationship with clients (Hutchinson et al., 2021).

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Family Therapy As An Intervention for Intergenerational Trauma

By Samantha Earp, Viola Ross, & Juhi Patel

Introduction

Intergenerational trauma is a phenomenon that impacts any person or group of individuals. This idea can have many different meanings, some may see it as a historical trauma while others believe it can be less historical and more about family patterns. Historical trauma is the trauma experienced by a specific group such as a racial group (Conroy, 2022). An example of this could be the impact of slavery or overall historical injustice on the African American community. The idea is that the mental health impacts of this injustice can be passed on from generation to generation. Although others believe that intergenerational trauma doesn't need to be historical it can be the idea that this trauma can happen within families that might have experienced individual traumas (Conroy, 2022). Some examples of this could be substance abuse, domestic violence, divorce or family separation.

Intergenerational trauma can have negative impacts not only on the individual but the family as a unit. An example of this can be if a mother has a history of depression they are more likely to show signs of irritability and be less engaged with their child (Jenson et al, 2021). For children who lack a caregiver, interactions can impact their cognitive and language skills (Jenson et al, 2021). We can easily begin to see how intergenerational trauma can form and carry on. Some other examples of intergenerational trauma and its impact can be parents who have experienced emotional or physical abuse are more likely to be controlling over their own children (Wang et al., 2022). Parents who have experienced sexual abuse have been shown to be associated with permissive parenting styles which have resulted in less structure and guidance (Wang et al., 2022). In general, intergenerational trauma has been shown to cause emotional dysregulation in children which can lead to health and behavioral problems. This can also be known as Adverse Childhood Experiences (ACES) (Wang et al., 2022). It is important that we tackle intergenerational trauma because helping one generation of a family has been shown to influence future generations (Jensen et al., 2020). This has been shown that guidance on treatments for those with trauma in the family can help those individuals who were exposed to trauma and hardship (Jensen et al., 2020). Much like general trauma, intergenerational trauma can have long and negative impacts on the family structure. In this paper, we will explore ways in which we as counselors can treat intergenerational trauma and help to end the cycle.

Family Therapy Interventions

As previously mentioned, intergenerational trauma can have lasting effects on individuals and their families. Given that this type of trauma involves the intertwining connections and experiences between people, family therapy could be a promising intervention. Mooren and colleagues (2022) discussed how attachment and the way families address crises can impact their children and their risk for mental health issues. Parents who carry unprocessed trauma or symptoms of PTSD are more likely to be hostile or aggressive with their children, resulting in attachment issues (Mooren et al., 2022). Mooren and colleagues (2022) proposed multifamily therapy as an intervention for intergenerational trauma, which involves conducting family therapy with groups of families. Their method addresses mentalization, emotional regulation, and empowerment as a way to enhance parent-child relationships and alleviate traumatic symptoms. In family therapy sessions, role-playing, modeling, group discussions, or video feedback can be used to increase the parents' mentalization, or ability to understand their own and other people's mental states (Mooren et al., 2022). To improve emotional regulation, family therapists can help parents to recognize when they are feeling triggered and

practice controlling their emotions so they are not taken out on their child (Mooren et al., 2022). With empowerment, therapists help to facilitate resilience by having each family group help each other and encouraging reliance on social support (Mooren et al., 2022). Ultimately, the intention of using multiple-family therapy for intergenerational trauma is for the families to provide support to one another and foster positive change while the therapist facilitates (Mooren et al., 2022).

When addressing intergenerational trauma, it is important to use culturally adapted interventions because culture can have a significant impact on the experience of trauma and healing from it. Lee and colleagues (2023) explored the use of trauma-informed socioculturally attuned family therapy (SAFT) on Black families who had been exposed to intergenerational trauma. Black individuals carry historical and generational trauma relating to slavery and continuous racial oppression which has lasting psychological effects (Lee et al., 2023). It is essential to consider social justice and cultural issues when working with this population, or other groups who have faced trauma as a result of historical injustice, which is why SAFT could be a valuable intervention. SAFT involves the therapist understanding and addressing the power imbalances and oppressive systems in place that impact the traumatic experiences of a family (Lee et al., 2023). Lee and colleagues (2023) encourage therapists to incorporate evidence-based trauma interventions, such as cognitive processing therapy or prolonged exposure therapy, into SAFT to create a culturally adapted method of healing intergenerational trauma for Black families. Addressing the social and systemic factors that affect marginalized populations is essential to help clients or families feel supported and validated for their experiences. Therapists should be well-informed about systemic oppression and social disparities, while also fostering a safe space in sessions so families feel comfortable talking about their culture (Lee et al., 2023).

Multicultural Considerations

In recent years, greater attention has been paid to how intergenerational trauma affects diverse populations and how family therapy can be adapted to fit the needs of these people. Researchers have found that people of color not only experience traumatic stress at rates equal to or higher than White people, but their traumatic stress symptoms are unique due to the complex nature of racial discrimination (Kirkinis et al., 2021). There is a distinct lack of research on intergenerational trauma due to racial discrimination, as most studies focus on individual experiences. This is especially puzzling, given that racial discrimination in the United States is a fairly recent reality that is still ongoing. Children today may grow up both experiencing racial discrimination themselves and witnessing their family members experience racial discrimination. It is worth noting that there is little research on how cultural factors other than race and ethnicity, like religion, sexual orientation, or socioeconomic status, are connected to experiences of intergenerational trauma. Most studies focus on how intergenerational trauma has affected the descendants of Holocaust survivors or Native Americans (Sirikantraporn & Green, 2016). However, despite the historical lack of diversity amongst studies on intergenerational trauma, more research is being conducted and released to study how individuals experience trauma symptoms because of the trauma experienced by their ancestors.

Family therapy focusing on addressing intergenerational trauma is also a growing focus of research, especially for multicultural clients. An emerging approach to family therapy is "socioculturally attuned practice" (Knudson-Martin et al., 2019, p. 47). This approach calls on marriage and family therapists to facilitate treatment that is sensitive and respectful toward clients' cultural

Family Therapy As An Intervention for Intergenerational Trauma (Continued)

values and concerns, particularly regarding power and systemic factors. Systemic factors disproportionately affect clients who do not fit the standard mold; in the United States, this standard mold would be a White, heterosexual, cisgender male with no physical or mental disabilities. Those who exist outside of any part of this mold are at the mercy of the existing systems that are not designed for their success. Family therapists who use "socioculturally attuned practice" can address not only the client's individual concerns, but also the greater societal systems that impact their daily functioning. When applying this lens to clients with trauma, the clinician can determine how their trauma was caused and perpetuated by the various systems in their lives.

Limitations

A major limitation is the lack of empirical research on both multicultural approaches to intergenerational trauma and using family therapy to treat intergenerational trauma. As mentioned above, research has tended to focus on a select number of populations; while this is currently changing, the research will still require time and effort to develop and garner support from other researchers. The gaps in research mean that clinicians may not have proper knowledge of treating intergenerational trauma in diverse clients and their families. Another limitation in using family therapy to treat intergenerational trauma is the difficulty clinicians may encounter in ensuring that critical family members attend sessions and do any assigned homework. It is known that older individuals and individuals from various ethnicities may not be as open to counseling as their younger family members who are seeking treatment. For family therapy to be truly effective, family members need to be present and willing to do the work to improve their functioning as a unit and as an individual. Clinicians need to be mindful of cultural beliefs about therapy and mental health when attempting to conduct family therapy to address intergenerational trauma.

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Skin-to-skin Contact: Could Birth Trauma Intervention be That Simple?

By Lindsey Brown McCormick

Over the last several years, the World Health Organization (WHO) has continued to emphasize the importance of breastfeeding and breast milk to infants' health and development (World Health Organization, 2003), which in turn has caused many countries to make breastfeeding a public health priority (Bigelow et al., 2014). There has been emphasis placed on the duration of breastfeeding, as well as the importance of exclusive breastfeeding, defined as feeding the infant only breast milk, no other solids nor other liquids (World Health Organization, 2004; Bigelow et al., 2014). The recommended duration of breastfeeding continues to be 6 months of exclusive breastfeeding, followed by continued breastfeeding with nutritionally adequate and complementary foods until the child is 2 years old (World Health Organization, 2004).

The benefits of breastfeeding infants are vast, and include a reduced risk of asthma, obesity, Type 1 diabetes, ear infections, and gastrointestinal infections (Center for Disease Control, 2023). Breastfeeding is also a protective factor against sudden infant death syndrome (SIDS) (CDC, 2023). There are also benefits to mothers and breastfeeding persons including lowering the risk of high blood pressure, Type 2 diabetes, ovarian cancer, and breast cancer (CDC, 2023). Further, breastfeeding stimulates the posterior pituitary to release oxytocin in the mother; oxytocin not only activates milk release from mammary glands, but also can also have a positive effect on maternal mood and induce feelings of attachment between mothers and infants (Bigelow et al., 2014). However, in the United States, only 1 in 4 infants is exclusively breastfed by the time they reach 6 months old (CDC, 2023). Many mothers report early cessation of breastfeeding due to inadequate support and education from healthcare providers, or problems such as low milk supply or painful feeding having a significant negative impact on their mental health (Scarborough et al., 2022).

Perinatal mood and anxiety disorders (PMADs) affect 1 in every 7 birthing persons (Postpartum Support International (PSI), 2023). PMADs include more than just 'postpartum depression' or 'postpartum anxiety'; PMADs also include postpartum Posttraumatic Stress Disorder (PTSD) often resulting from a traumatic birthing experience. Up to 9% of women experience PTSD following a real or perceived traumatic birth that includes an unplanned emergency Cesarean surgery, the use of a vacuum extractor or forceps, or the infant being admitted into a neonatal intensive care unit (NICU) (Postpartum Support International, 2023). Some researchers have found this percentage to be even higher, with up to 30% of women reporting experiencing delivery-related posttraumatic stress symptoms in the weeks following birth (Alcorn et al., 2010; Joris et al., 2015; Coojimans et al., 2022). The Birth Trauma Association (BTA, n.d) has defined birth trauma as PTSD and includes mothers who have experienced PTSD after birth. However, some researchers identify birth trauma as an injury sustained by the infant during the process of labor and delivery (Sauber-Schatz et al., 2010). Traumatic birthing experiences can also significantly impact the formulation of a secure attachment style, one reason being the delay in the warmth and connection needed from their mother or birthing parent (Prigel, 2018).

Mother-infant skin-to-skin contact (SSC) is a method of providing newborn infants with close body contact (Bigelow et al., 2014). The infant is place between the mothers breasts, wearing only a diaper, so that frontal body contact of the mother or birthing person and infant are skin-to-skin; the mother secures infant, typically through holding, and the duo is covered (Bigelow et al., 2014). The effects of mother-infant SSC on newborns' neurophysiological adjustment to life outside the womb are well documented (Bystrova et al., 2003;

Skin-to-skin Contact: Could Birth Trauma Intervention be That Simple? (Continued)

Christensson et al., 1992; Ferber & Makhoul, 2004; Moore et al., 2007; Moore et al., 2012; as cited in Bigelow et al., 2014), and SSC has been shown to increase rates of breastfeeding (Bramson et al., 2010; Meyer & Anderson, 1999; Moore & Anderson, 2007; as cited in Bigelow et al., 2014). SSC has also shown to have positive effects on maintaining breastfeeding through the infants' early months, which is often the time mothers terminate breastfeeding (Bigelow et al., 2014).

Now, dear readers, you may be wondering how and why all these things are connected. In November 2021, I had my own traumatic birthing experience. Postpartum, I experienced a range of problems that caused me to consider early cessation of breastfeeding and/or supplementing with formula; I struggled with severe anxiety and intrusive thoughts regarding my baby and its safety. I experienced, firsthand, similar situations that I have helped previous clients process and heal from. But I did not know how to heal myself. In many ways, SSC was the intervention I desperately needed. In my own phenomenological experience, SSC helped to ease my anxiety, helped to ease my fears and concerns surrounding breastfeeding and an inadequate milk supply, helped to facilitate bonding between my child and myself, and helped my child feel secure when they were dysregulated.

After my own experience, my new sense of purpose as a trauma professional is to help other mothers and birthing persons struggling to make meaning from traumatic birthing experiences and help other clients struggling with PMADs. It is to educate and advocate on the importance of SSC, and to educate others working with birthing persons on the benefits of SSC from a healing perspective, through a trauma-informed lens, from a public health perspective, and for the benefit of perinatal and infant mental health. So, is it as simple as SSC? We do not have the answer quite yet, but I am on a quest to find out.

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COMMITTEE AND TASK FORCE UPDATES

Advocacy Committee

Branch Committee

Budget and Finance Committee

Bylaws Committee

Communication, Media and Public Relations Committee

Conference Committee

Diversity, Equity, Inclusion, and Social Justice Committee

Graduate Student Committee

Membership Committee

Awards Committee

To join a committee, please send your **CV and letter of interest** to IARTC Past President Dr. Peggy Mayfield (Mayfield.peggyc@gmail.com), IARTC President Dr. Lisa Levers (levers@duq.edu), and IARTC President-Elect, Dr. Matt Walsh (walsh1714@gmail.com). If appointed to a committee, we will also need a **headshot and a brief bio** so that we can add your profile to the IARTC website. **IARTC needs you!**

IARTC RESILIENCE & TRAUMA EXEMPLEMARY AND COMPETENCIES TASK FORCE

The task force was established to examine the facets trauma and resilience with a goal to develop evidence-based core counseling exemplary practices/competencies. The resulting foundational guidelines will advance pedagogy, epistemology, practice knowledge, and research related to trauma and resilience through a global framework. This multiphasic research is well underway, having completed Phase I. Phase II is in progress. More details to follow. Members of the Task Force include:

Dr. Naomi J. Wheeler, Ph.D., LPC (VA), LMHC (FL), NCC--Chair
Assistant Professor, Counselor Education
Counselor Education & Supervision, Doctoral Program Coordinator
Couple and Family Counseling specialization Coordinator
Department of Counseling and Special Education
School of Education | Virginia Commonwealth University

Dr. Eric Brown, PhD, LPC (IL), NCC--Co-Chair
Assistant Professor
Department of Psychiatry and Graduate Medical Sciences
Mental Health Counseling and Behavioral Medicine Program
Boston University Chobanian & Avedisian School of Medicine

Dr. Autumn Cabell, Ph.D., LPC, CCC, NCC, CCTP
Assistant Professor
Assistant Professor, Counseling
DePaul University, College of Education
IARTC Newsletter Editorial Team

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Assistant Dean of Student Health, Wellness, and Counseling
Gonzaga University
Secretary, Chi Sigma Iota International (CSI)
Treasurer, North Central Association for Counselor Education and Supervision (NCACES)

(Membership Continued on the next page.)

IARTC RESILIENCE & TRAUMA EXEMPLEMARY AND COMPETENCIES TASK FORCE

Additional Members of the Task Force include:

Dr. Denisa Millette, PhD, LPC, CPCS
Licensed Psychotherapist
Certified Professional Clinical Supervisor
Certified Clinical Trauma Professional
Professor of Psychology, Yorkville University, Canada
Chair of the IARTC Professional Development Committee
Founder of Safe Emotions Counseling, LLC

Dr. Jiale Man, MS, LGPC, PhD, NCC
Assistant Professor
Clinical Mental Health Counseling (CMHC)
Seattle University

Dr. Peggy Mayfield, Ph.D., LCPC, NCC, CCMHC, CCTP, CFTP, DCMHS
President (2022 - 2023) & Co-Founder, International Association for Resilience and Trauma Counseling
ACA Traumatology Interest Network Leadership Team
United Nations NGO Committee on Mental Health
Prevent Child Abuse Illinois Board Development Chair

BRANCH COMMITTEE

Representative: Yoon Suh Moh, Chair of Committee
Credentials: Ph.D., LPC (DC and PA), CRC, NCC, BC-TMH
Work affiliation: CACREP accredited community and trauma counseling program at Thomas Jefferson University

The Branch Committee consists of the following members:
Yoon Suh Moh (Chair), Jerry Pierson (Vice Chair), Fariba Ehteshami (Member), Fatemah Alghamdi (Member), Sophie Oswin (Member)and Yahyah Smadi (Member).

The Branch Committee of IARTC is a group of dedicated volunteers and members of IARTC and ACA who help promote the development of a branch of IARTC. The Committee involves diverse counseling professionals (counselors, counselor educators, and medical providers) and counseling students.

During the previous year, the Branch Committee created application materials, an application form, step-by-step infographic, and checklist for the use of submitting applications. When these materials are granted final approval, they will be uploaded on the IARTC website.

This year, the Branch Committee will help facilitate the development and enhancement of branches of IARTC using the application process it has established.

We always welcome new, additional members.

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IARTC'S 1,300+ MEMBERS LIVE IN 50 STATES, D.C., PUERTO RICO, BRITISH COLUMBIA, CZECH REPUBLIC, ONTARIO, ITALY, MALAWI, SINGAPORE, SYRIA, SWITZERLAND, AND THE UNITED KINGDOM

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TOGETHER WE THRIVE!

Dear Readers,

We hope you have enjoyed this edition of the IARTC newsletter! We look forward to bringing you the Spring Newsletter in 2024.

We accept submission all year round. We ask submissions be relevant to resilience and trauma counseling issues that impact counselors and/or those they provide counseling to (students/clients). Submissions should be written in and comply with APA 7 formatting guidelines. The length should be between 1000-1500 words (including references).

Anyone can submit, members and non-members. Please email your submission in a word document to: newsletter.iartc@gmail.com with a copy to foremant@ohio.edu.

Feel free to reach out to if you would like to suggest a theme idea for future newsletters.

Sincerely,
Your Newsletter Editing Team
Tamarine Foreman, Charmayne Adams, and K. Lynn Pierce

Be Well. Stay Well.