# Trauma Matters

Spring 2022

A quarterly publication dedicated to the dissemination of information on trauma and best-practices in trauma-informed care.

**INSIDE THIS ISSUE:**





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## Helping the Helpers

### Support for Healthcare Staff in COVID-19

by Christine Bihday, MSN, PMHNP-BC, ANP-BC

In early March of 2020, as the novel coronavirus (COVID-19) landed in the U.S., a small group of mental health providers and I came together to develop a plan to support frontline healthcare staff at the Veteran's Administration (VA) Hospital in Connecticut. As a former ICU nurse, a Psychiatric-Mental Health APRN and Adult APRN, and the **Employee Assistance Program (EAP)** Coordinator, I—and my colleagues—understood that frontline staff were at risk not only for acquiring COVID-19 but also for acquiring a host of other conditions: stress, anxiety, mental illness such as Post Traumatic Stress Disorder (PTSD), moral injury, compassion fatigue, burnout, and more—all which can have an adverse effect on patient care. Our intent was to provide a variety of ways to offer emotional support to staff and to reduce the likelihood of developing longstanding mental illness through the development of resources, programming, and greater accessibility to counseling services through EAP.

The group, **EAP COVID-19 Employee Support Team**, was anchored in the EAP, and the team consisted of dozens of VA staff, including psychologists, social workers, chaplains, nurses, nurse practitioners, psychiatrists, Veteran peer specialists, and addiction therapists, all of whom volunteered their time and unique expertise apart from their normal job duties to make a positive impact on staff wellness. **Psychological First Aid (PFA)** was chosen as the initial and main framework for staff outreach. PFA, developed by the National Child Traumatic Stress Network and the National Center for PTSD, is an evidence-informed modular approach to assisting all people in the immediate aftermath of a disaster, and to foster short- and long-term adaptive functioning. It is best delivered within 72 hours of a critical incident or disaster but can be used for weeks thereafter. The 8 PFA core actions are the following: (1) contact and engagement, (2) safety and comfort, (3) stabilization (if needed), (4) information gathering on current needs and concerns, (5) practical assistance, (6) connection with social supports, (7) information on coping, and (8) linkage with collaborative services. PFA is not psychotherapy, can be delivered by laypeople, takes on a nonjudgmental and culturally sensitive approach, and never assumes that individuals don't have the skills to cope, but rather builds on existing coping skills and helps with problem solving.

The PFA model was utilized through "boots on the ground" walkabouts in pairs—to model the buddy system—to support frontline staff in inpatient units, ERs, and primary care, specialty and mental health clinics. Early on we found that most staff concerns were grouped into 4 categories: (1) worry about acquiring or transmitting the virus to a loved one at home, (2) receiving accurate information in a time of uncertainty and change, (3) having adequate and effective personal protective equipment (PPE), and (4) coping with death of patients with COVID-19, much like other hospital staff throughout the country. During unit walkabouts we became a familiar presence, led impromptu and scheduled mindful moment exercises, listened to staff's fears and concerns, and—when appropriate—delivered the concerns to leadership to create solutions. At times we were present with staff during moments of tears, exhaustion, and grief, and brought staff together when a beloved Veteran died of COVID-19, an experience that sometimes went so against staff moral beliefs or expectations that it brought on moral injury. Alternatively, when there was laughter and joy on the units, we supported savoring such moments to build

**Medical personnel don PPE before entering a COVID-19-positive, non-critical patient's room. Photo courtesy of Official U.S. Navy Imagery.**

on resilience: the ability to bounce back from adversity. Some of the most remarkable times were when we witnessed or participated in moments of obvious staff resilience on the units, such as creating pandemic birthday songs, sharing photos of pets, children and sunsets, and dancing to music with staff.

What started out as an approach to support frontline staff quickly grew to the realization that *all* hospital staff could benefit from support, given their similar fears of COVID-19, their difficulty adapting to a changing work/life environment, the effects of social isolation, the need for information on coping with stress, and other concerns. We built a variety of modalities to reach out to and support staff, including but not limited to: an EAP newsletter; a SharePoint with community resources, prerecorded mindfulness links and accurate information; EAP and stress management flyers posted hospital wide; live virtual Complementary and Integrative Health (CIH) offerings such as mindfulness and yoga; live "Coping During COVID-19" calls on topics such as stress management; supervisor consultation; and expanded individual EAP counseling through virtual appointments. A Mental Health Disaster Team was also formalized to support staff in the acute aftermath of additional traumas and disasters.

Similar to the challenges providers had transitioning to a virtual platform for patient care, we ran into obstacles such as finding the most effective virtual platform for programming and creating psychological safety in a virtual setting. We also recognized that staff working in different environments had unique needs—new teleworkers, employees who are also Veterans, staff with school age children, and supervisors, for example, all required different resources. To address these diverse needs, we created virtual programming specifically for teleworkers; worked with Veteran Peer Specialists to outreach Veteran employees; invited Yale Department of Psychiatry to bring in experts on child psychology for virtual programming; expanded walkabouts to staff in non-patient care areas; and created drop-in supervisor support groups, including supporting supervisors through grief and loss, lead by EAP and Chaplains, to name a few.

Programming for staff evolved throughout the pandemic based on additional stressors, the ever-changing needs of staff, staff survey data, and keeping up with research and VA national programs. First, the EAP COVID-19 Employee Support Team incorporated the **Whole Health** model into staff programming. Whole Health is the VA's approach to care for Veterans and staff that supports health and well-being, and centers around what matters to *you* while focusing on self-care, skill building and support. VA CT merged with our VA northeast region and created a Wellbeing Calendar of Whole Health and virtual live CIH offerings such as mindful moment, yoga, and spirituality. Second, some of our team participated in a multi-site VA **Stress First Aid (SFA)** pilot for workgroups. SFA is a model of peer support and self-care for high-risk occupations that creates a common language for stress using the Stress Continuum Model and promotes key actions that help people recover from stress. Lastly, as hospitals throughout the U.S. are now faced with high rates of burnout and unprecedented staffing shortages, many hospitals are employing a **Chief Wellbeing Officer (CWO)** who serves in a leadership position and whose primary role is to put staff wellness first in hospital-wide decision-making processes and in creating a culture of staff wellness. The CWO is presently being piloted at a few local VAs.

During these past two years of the ongoing pandemic, our EAP COVID-19 Employee Support Team did not solve the problem of staff burnout, and many staff are experiencing stress and mental health problems because of the challenges they have faced. COVID-19 has impacted all of us, including the Employee Support Team. However, the team did effectively develop over 10 new wellness and stress management programs and resources for staff when we had only one before we started—the EAP program—and these programs and resources have made a difference. Through our work over the last two years, we made an impact on culture change in terms of prioritizing staff wellness, introducing mindfulness and an array of coping strategies to build resilience in the workforce, and destigmatizing stress and other related emotions in the workplace. Thanks to these efforts, we have created a culture where staff know that it is "ok" to reach out to their peers, supervisors, EAP, or others for support, and conversely, that it is alright for staff to check in with their peers if they too seem stressed. As much continues to remain uncertain in our world, and as we face additional serious challenges on the local and global scales, frontline and healthcare staff well-being *must* continue to be prioritized and ingrained in the workplace culture long after COVID-19 becomes endemic. With dedicated and paid staff in employee wellness roles such as EAP coordinators and counselors, CWO, and more, we can continue to provide and foster the resources and environment necessary to better support our staff and, in turn, the patients in our care.

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*Christine Bihday is a former ICU nurse, now dual-certified as a psychiatric mental health and adult nurse practitioner, and provides psychiatric care to Veterans in a virtual Mental Health Clinic at VA Connecticut Healthcare System. Her primary role is supporting VA staff as the Employee Assistance Program Coordinator and Employee Whole Health Coordinator. Ms. Bihday is also a certified yoga instructor and leads staff in virtual yoga and mindfulness classes*.

## Featured Resource: *Drawing Breath: The Art of Breathing*, by Tom Granger

**By Colette Anderson, LCSW**

I had the pleasure of meeting the author, who is based in England, at a statewide Integrative Medicine Committee meeting where he was presenting. He did a few of the exercises with the group. I was immediately excited and decided to order the book. As a person who has difficulty staying focused when doing mindfulness and meditation, I found I stayed focused when combining it with drawing. Getting into a space to breathe while drawing is a nice way to quiet the mind.

Tom said, "The exercises in Draw Breath are designed to deepen the connection between your body, mind, and breath. With the help of fun, relaxing, and creative

challenges, we will explore and unlock the techniques that allow us to master our brains and bodies using our breath."

This book is divided into three parts: body, mind, and spirit, with each expanding on the last. It is designed to be completed from front to back. The exercises in the book are rewarding, and the experience of going through them will be unique for each person. This book is a great way to relax and build a connection with your body and mind. Check it out and see what part of the book you are drawn to—it can become your mini retreat.

## Urban Post-Traumatic Stress Disorder

**By Erica Reshard, LADC, LCSW, ADS**

The DSM–5 informs us that post-traumatic stress disorder (PTSD) has a specific set of criteria. Based on the criteria, events can be experienced directly or indirectly. In the case of veterans and victims of abuse or violence, the experience is more likely to be direct. Survivors of natural disasters, acts of terror, and racialized trauma also tend to experience the trauma directly. Indirect exposure may be experienced by first responders, mental health professionals, and empathetic people of all kinds, including but not limited to family members and loved ones of individuals who have experienced direct trauma. Just like people in war-torn countries, United States citizens who live with the sounds of gunshots, police and ambulance sirens, or helicopters tend to be constantly on alert. This type of exposure, in addition to the threats of violence, poverty, racism, incarceration, and generational trauma, plagues the lives of many inner-city residents, young and old alike. Undoubtedly there is a ripple effect in communities where this violence takes place and in the homes of the victims, perpetrators, and neighbors of those involved. It is imperative that those entrusted to serve inner-city residents are well-versed in urban PTSD and understand cultural humility.

It is all too often that we hear about stray bullets hitting innocent people in communities where violence is a regular occurrence. We have heard about children who have been killed or injured while playing outside of their homes, and we have also seen reports of bullets entering homes and killing or injuring those inside who have nothing to do with the outside altercation. Parents, children, relatives, and friends in the area are all affected by things that leave indelible imprints on their psyche. In short, we have entire communities that are being regularly traumatized. Unlike traumatic experiences that happen as a one-time event from which a person can distance themselves, inner city violence can occur so frequently and in so many places that individuals are not likely to be able to remove themselves from the area or avoid things that remind them of traumatic events.

Some children are exposed to violence that may result in a post-traumatic stress disorder diagnosis. The symptoms of PTSD in children often appear in environments that are not equipped to address them. School officials may notice poor test scores, slipping grades, short attention spans, and violent outbursts in a significant number of their students. While poor grades, an inability to sit still, and a lack of concentration would appear to most to be examples of attention-deficit/hyperactivity disorder, some teachers and administrations recognize that the children who experience these symptoms may come from the most violent neighborhoods in their city, and many of them have witnessed or been touched by homicide or some type of trauma usually related to violence. According to a 2007 report by the *San Francisco Chronicle*, "as many as one-third of children living in our country's violent urban neighborhoods have PTSD," which is almost two times the number of veterans coming home from the Middle East. Most policymakers have no idea; very often, these children do not get diagnosed or receive treatment, so PTSD never comes to their attention, nor to the attention of school officials. Teachers at some inner-city schools have seen PTSD manifest itself in emotional outbursts that appear to be unprovoked, clenched fists, uncontrolled rage, subpar schoolwork, and playground fistfights. Although these symptoms are normal based on the experiences these children have had, many times they do not understand—nor are they taught to understand—what is happening with them.

Adults often have post-traumatic stress disorder resulting from adverse childhood experiences that remain with them into adulthood. In addition to childhood experiences, other personal risk factors include having previously experienced assault, being younger at the time of the event, a history of mental illness, and being of lower socioeconomic status. People of color, women, and individuals who lack social support are also at higher risk for developing PTSD. Inner-city residents may readily fit the criteria, and because of community or interpersonal violence, find themselves suffering from PTSD. The average inner-city resident may suffer from the same common co-morbidities as inmates, i.e., depression, substance-use disorders, and anxiety. They may also struggle with less documented comorbidities, including troubled relationships, domestic violence, and health problems such as strokes and heart attacks. Individuals with PTSD are more likely to require public assistance from social services and to be unemployed, and some individuals with PTSD are too impaired to work.

When despair and rage copulate, communities become pregnant with loathing and give birth to gangs. As gang violence is common in the inner city and synonymous with criminal activity and drug use, many individuals who are from the inner city have lost someone close to them due to violence or drug use. Retaliation is common amongst those who are involved in gang activity and other illegal activity. It is not unusual for disempowered males to lash out with violence and anger. Men who cannot find employment to provide for their families can get caught in the vicious cycle of incarceration and recidivism. This cycle drags them deeper into a pit of failure that may cause them to have a great deal of anger. Again, combined with racism and poor living conditions, these circumstances can be incredibly stressful, to the point of being traumatic. Self-destructive behavior is common for people who live in despair and see no way out of a bad situation. This may look like a reckless lifestyle with a disregard for one's safety, and sometimes no regard for the safety of others as well. Such behavior often leads to incarceration, which becomes yet another site of violence and trauma.

Inmates in correctional institutions all over the world have been identified as suffering from post-traumatic stress disorder. The public tends to forget that inmates may also be victims of violence, and gender does not make a difference with relation to trauma and incarceration. This includes both psychological trauma and victimization. A good majority of inmates enter the criminal justice system with a history of trauma, and many experience trauma while incarcerated. Inmates may continue

to exhibit the symptoms of PTSD long after release from prison, even if the only trauma they experienced was while incarcerated. This has been referred to as "Post-Incarceration Syndrome" (PICS), and while it is not listed in the DSM-5, it is recognized by many as a subtype of PTSD.

Post-incarceration syndrome is characterized by the results of long-term incarceration, which include but are not limited to signs of institutionalization and social deficits. Inmates who are identified as having PTSD or PICS may present with co-morbidities including depression, anxiety, and substance-use disorders. There is ample research to link incarceration to PTSD. Many people return to or relocate to inner cities after incarceration because they are rich in reentry resources compared to more rural areas, thus further saturating these communities with members who have experienced traumatic events.

Urban trauma and the inner-city residents who are affected by it deserve to have adequate research and data to allow for the development of evidence-based treatments specific to this population. Inner-city residents deserve to have their trauma acknowledged and to be cared for in the way that veterans, immigrants, refugees, and other traumatized populations are validated and cared for. The population and the cultures it encompasses should be understood by those who take an oath to serve them, as so many subcultures exist just below the surface and may require unique and culturally competent approaches. In conclusion, everyone in a helping profession serving urban communities should be required to receive training in urban PTSD. It is imperative that inner-city residents' voices are heard and processed with a culturally humble cognizance to ensure culturally appropriate and effective treatment.

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*Erica Reshard, LCSW, LADC, ADS has been working in the human service field for over 25 years and received her MSW at Southern Connecticut State University. Erica has worked with marginalized populations for the majority of her career and has developed a passion for working with the disenfranchised and inidividuals suffering from urban PTSD. In 2015, she opened Sankofa Counseling, where she provides individual counseling using a trauma-informed, culturally-competent approach. She is currently matriculating toward her Doctorate of Social Work degree at Southern Connecticut State University.*

# Ask the Experts: An Interview With Peter Pruyn, LMHC

**By Emily Aber**

*Peter Pruyn, LMHC, (pronounced "prine") is a psychotherapist and EMDR Consultant who specializes in working with female survivors. He is in private practice in Northampton, Massachusetts and has a research interest in treating endometriosis pain with EMDR. He is the author of Psycho-Ed Handouts for Trauma, EMDR, and General Psychotherapy, 3rd Edition and is a member of the New England Society for the Treatment of Trauma & Dissociation. His favorite self-care activities include piano, meditation, writing, cycling, guitar, photography, and improv comedy. His writing can be found at peterpruyn.medium.com.*

**MS. ABER: How did you become interested in treating trauma and endometrial pain?**

MR. PRUYN: Before I answer that, I want to start by just listing my limitations in this conversation. I am not a medical doctor, and endometriosis is possibly the most complex disease I've ever encountered, so everything I've learned about it has come from those in the medical profession and my clients. And that leads to my second limitation, which is: I don't have a uterus! And that means I am dependent on learning about the experience of the disease from those who have it. So in that way, I'm sort of a permanent beginner.

But to answer your question, I think it first began when I was an intern at Lesley University, which is an overwhelmingly female-dominated campus. I was an intern at the student counseling center, and the overwhelming majority of clients who would come to the center were female. That was my introduction to women's issues—being exposed to body image issues, eating disorders, sexual assault, and so forth. It's important to note that I never set out with any particular goal of what to specialize in; I just sort of followed the breadcrumbs of the need. But what happened was that I interned at a homeless shelter, I was a substance abuse counselor in a methadone clinic, and those experiences taught me first the prevalence of trauma—that the world sort of pretends that trauma is the exception rather than the rule, when in fact it's the opposite—and second, that the female clients were much more likely to have a sexual abuse history. So then when I went into private practice . . . the majority of my clients were female, and the work around sexual assault and women's issues continued. Then it would only be a matter of time that one of my clients disclosed to me that she suffered from endometriosis. And although I had heard of it, I want to make clear that it was my complete ignorance of the details of the condition that set me off on a crash course of understanding it.

First of all, the endometrium is the tissue that lines the inside of the uterus, and if you do an internet search for endometriosis, you are likely to find the following description of what it is—it'll say something like, "Endometriosis is when the endometrium grows outside of the uterus, and when it bleeds, it causes excruciating pain." And unfortunately, that is a grossly oversimplified description. First of all, the tissue that may grow outside of the uterus is not the exact same tissue, and there are as many different presentations of endometriosis as there are people who have it. No two cases are the same. Some involve internal bleeding, some don't. So a more accurate description would be that "Endometriosis is an inflammatory condition, and its most common symptom is pain, and it's also a leading cause of infertility."

And then the other piece that really got me continuing to look into it was just the prevalence—of which I had no idea. Endometriosis affects 1 in 10 women, or transgender individuals who menstruate. That's the same rate as diabetes, and yet many people have never even heard of it. I was really struck by that. I remember a statistic that if you put all the people in the world who have endometriosis together, it would be 176 million people, and that would form the 8th largest country. On top of that, we don't yet know what causes it,

and there is no simple cure. But what we do know is that there is a very high correlation between childhood trauma and developing the condition. Individuals who identify as having an acute abuse or trauma history have a 79% higher chance of having the condition. And so as a trauma therapist who works primarily with female survivors, it would only be a matter of time before I encountered someone who had it.

. . .

**MS. ABER: What theoretical background informs your work, and are there particular approaches you've found helpful in working with trauma?**

MR. PRUYN: When I see this question, one of the things I think of is a colleague who offered a really lovely diagnostic question for when you're looking for a therapist for yourself. They suggested that you ask the therapist, "Do you see psychotherapy as a science or an art?" And I've always loved that question. The way I would answer it is, "I see psychotherapy as an art that is informed by science." I really don't know anything like doing trauma therapy. It is a moment-to-moment, intrinsically collaborative, organic, intimate, intuitive process. And so the theoretical orientations are helpful, but I can't help but emphasize that there are grandmothers, taxi drivers, and hairdressers who I think can be better therapists than those who have read a whole bunch of research, because they're really in tune with a person.

You're probably already inferring that I'm heavily influenced by a person-centered or humanistic approach—I remember my first supervisor trained with the Carl Rogers community in California, and he used to like to say, "Technique is what happens before the therapist arrives." I've never forgotten that.

I'm also influenced by a psychodynamic approach, and I'm influenced by feminist ideas of this work, which for me really focus on power dynamics—both the power dynamics in society that may have contributed to the client's symptoms and why they're there, but also making explicit the power dynamics between me and my clients in my office. One of the things I like to highlight for my clients is how their expertise and their own self-knowledge is actually more important than any expertise I might bring.

I think if you do trauma work, you can't help but be influenced by concepts of mindfulness, whether you see that as a stance, a practice, or a technique. And that is a close cousin of what I would call spirituality, without trying to define exactly what that word means. I think in trauma work we're focused on making meaning of experience—I think all psychotherapy is—and to just sort of keep in the back of your mind the role that connection, purpose, identity, and meaning make in this work, regardless of whether the client is religious, spiritual, or an atheist.

I would identify as being integrative, as far as technique. The cornerstone of my work is EMDR, but I also want to give a shoutout to my first trauma mentor, Deborah Korn, and an integrative approach—looking at many different approaches to psychotherapy: Internal Family Systems, Accelerated Experiential Dynamic Psychotherapy (AEDP), expressive therapies . . . I think being able to be on the lookout for when a creative activity would be helpful, whether it's art, or music, or dance, or movement. And then I also like to make explicit that humor is a creative process, too. I think people would be surprised at how often I find myself laughing with my clients. That doesn't mean that everything is funny, but humor can be healing when it's used appropriately.

**MS. ABER: Could you please tell us about your retrospective case study, and any plans for future research?**

MR. PRUYN: I had a client—who I will call Shauna—who came to me originally with intense anxiety around driving. She also had a very extensive history of medical trauma. About six months into treatment, she was afraid of canceling a session because of very acute period pain, and in that conversation, she disclosed that she suffered from endometriosis. So that led us down a path of using EMDR to treat her chronic pain.

It's very, very important to emphasize, once again, that I am not a medical doctor: I am not in a position to treat any of her physical symptoms. But one dynamic of chronic pain is the role that memory plays in a person's experience of it, and EMDR is something that works with memory.

I'm going to read a very brief excerpt from the case study, and then just talk about some of the things it brings up. As people who do EMDR will know, one of the things you do is choose a starting memory to reprocess. We decided to use a memory of her lying on the bathroom floor in pain as the starting point for the EMDR processing:

The next step was to identify a negative belief that might be underlying how she thought about her pain in that moment. Shauna realized that part of her experience of lying on the floor was thinking, "My body is bad." Next, we identified a positive belief that she would prefer to believe about herself instead. She came up with, "My body is good."

Over the course of the session, Shauna began to piece together her personal history of menstruation. She recalled how growing up, menstruation was a taboo topic in her home; the first time she talked about it in-depth with her mother was after she got her first period and waited two days to tell her mother, because she was embarrassed and worried that she had done something wrong. Like many women, she was raised to be ashamed of menstruation, and that one of her jobs as a woman was to make sure that no man ever knew she was having her period. Some characterize this as a "culture of concealment" around menstruation that exists in most cultures around the world. As Shauna put it, "I didn't know I needed to talk about this." Adding endometriosis pain to this picture only intensified her feelings of isolation, self-blame, and self-loathing that she was feeling as an adult.

At the end of the session, I asked her what her main takeaway from today's processing was. She said, "If the body I'm in now is good, then the body on the bathroom floor is good, too." The next week, I asked if anything felt different about her period pain this month. She said that while her pain had been average this past week, what felt different was giving herself permission to be gentle with herself. All her life, her strategy for dealing with period pain had been to try to push through her day as if nothing was wrong. It was a novel idea that there were other ways to cope available to her.

At her second processing session, she said that she was beginning to believe that her body was good and realized that it wasn't helpful to "try and control the pain with my brain." As a result, she was paying more attention to what her body was telling her, including in other areas of her life: for example, when it was telling her to go to sleep. An unexpected result of this shift in mindset towards self-care was that she was beginning to believe "I matter." As she said this out loud, she teared up.

The reason I chose that excerpt is that I wanted to give a flavor for the kind of work we're doing . . . we're not trying to directly change the physical symptoms—we're trying to explore the client's psychological experience of the pain, and that is often influenced by negative beliefs. If these negative beliefs can be healed, then the pain can sometimes be lessened. In her case, over about half a dozen EMDR sessions, she reported that prior to working with me, her average period pain on a scale of 0-10 was a 7-9. And in the year since doing this, she has reported that her average period pain has been about a 4. In fact, last month it was a 3. And all of that was not me working on the body directly, but on her psychological experience of the pain.

**MS. ABER: Wow, that's significant! And that's without medication, I assume?**

MR. PRUYN: That's correct.

**MS. ABER: I understand that you've also worked in consultation with a medical expert on a three-question survey to ask patients, and I thought you could tell our readers and listeners more about that.**

MR. PRUYN: I want to give a shoutout to whom I consider my endometriosis mentor: her name is Heather Guidone, and she is Surgical Program Director of the Center for Endometriosis Care in Atlanta, Georgia. She is a wealth of information about endometriosis. We collaborated on coming up with three screening questions that we proposed all therapists add to their intake paperwork. They're very simple, and you can ask someone to rate them on whatever scale you like . . . They ask them to rate: pelvic pain; painful sex; and debilitating periods, that is, impairing regular daily routines. And those three things—pelvic pain, painful sex, and debilitating periods—are highly correlated with endometriosis. So these are in no way going to give a diagnosis, per se, but they're an entryway into potential conversation. . . . And as my client emphasized, she never would have dreamed that she would be talking to a psychotherapist about her periods.

**This interview has been abridged for length and clarity.**
**To listen to the full version, visit:**
**www.womensconsortium.org/podcasts**

## Who's Been Reading Trauma Matters? Emily Hoyle!

**By Morgan Flanagan-Folcarelli**

Emily Hoyle is a former editor of *Trauma Matters* and a graduate student in political communication at American University. She received her Bachelor of Arts degree in political science from Portland State University, where she honed her lifelong interest in politics into a focus on political communications during a junior year internship in the office of U.S Senator Jeff Merkley. She credits her mentor, Sara Hottman, with teaching her about the impact of political communications and the difference she could make doing this work.

In her previous role as the Community Project Coordinator at the Connecticut Women's Consortium, Emily developed a professional focus on gender that would come to inspire her vision for her career. The Consortium's work on gender equity in behavioral healthcare reminded her of her own experiences with discrimination in healthcare; working alongside Kathleen Callahan, MSW, on the Consortium's legislative agenda, Emily saw a path to joining her interest in politics with advocacy for women. Her time as the Consortium's communications lead also assisted her in developing the vocabulary to confidently speak to feminist issues and apply both the Consortium's lens and her own to public-facing work.

Emily describes her time as Editor of *Trauma Matters* as "a momentous experience," one that helped her develop management skills and an editorial background that will support her throughout her career. She credits the *Trauma Matters* Editorial Board, Shannon Perkins, LMSW, and Colette Anderson, LCSW, for the opportunity to learn so much about behavioral health through the publication, all of which has advanced and impacted her advocacy goals.

Alongside her studies, Emily continues to work in progressive circles for women. She is currently a communications intern at EMILY's List, a political program and donor network committed to driving progressive change throughout the U.S. by winning elections that put Democratic pro-choice women into office. Her dream after graduation is to continue working in political communications with organizations that advocate for women.


**Emily Hoyle, pictured above with a recent copy of *Trauma Matters.***

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www.womensconsortium.org

# References and Resources


**Helping the Helpers: Support for Healthcare Staff in COVID-19**

EAP Employee Assistance Programs (opm.gov)

PFA About PFA | The National Child Traumatic Stress Network (nctsn.org)

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Stress First Aid Stress First Aid: Manual and Resources for Health Care Workers - PTSD: National Center for PTSD (va.gov)

Chief Wellbeing Officer (CWO) What is a chief wellness officer? | American Medical Association (ama-assn.org)

**Urban Post-Traumatic Stress Disorder**

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**Ask the Experts: An Interview with Peter Pruyn, LMHC**

Medical Resources: Center for Endometriosis Care, a medical practice in Atlanta, Georgia that specializing in treating endometriosis. Includes extensive resources: https://centerforendo.com/

Book: *Beating Endo: How to Reclaim Your Life from Endometriosis* by Iris Kerin Orbuch MD, Amy Stein DPT (2019). Two leading experts describe their integrative approach to understanding and treating endometriosis: https://www.harpercollins.com/products/beating-endo-iris-kerin-orbuch-mdamy-stein-dpt?variant=32903931691042

Survivor Memoir: *I Have the Right To: A High School Survivor's Story of Sexual Assault, Justice and Hope* by Chessy Prout and Jenn Abelson (2018). A page-turning account of Prout's assault, recovery, and legal battle against St. Paul's boarding school where she was raped by a graduating senior. Along the way an inspiring portrait of trauma and trauma recovery written by a teenager and an investigative reporter. See a summary of the book I wrote from a clinical perspective here: https://tinyurl.com/yfgtquwp

Film: *Aly Raisman: Darkness to Light*. An accessible, comprehensive, thoughtful, and poignant documentary about a survivor's journey to empower other survivors: https://www.d2l.org/aly-raisman-darkness-to-light/

Prevention Group: The Consent Collective, Dr. Nina Burroughs (in the U.K.) and her book, *The Courage to Be Me*: https://www.consentcollective.com/

Non-profit for Healthy Masculinities: Promundo, a non-profit promoting global gender equality and preventing violence by engaging men and boys in partnership with women and girls, including its Manhood 2.0 program: https://promundoglobal.org