VOLUME 14 SUMMER-FALL 2026

A PUBLICATION OF
THE AMERICAN ACADEMY OF EXPERTS IN TRAUMATIC STRESS
THE NATIONAL CENTER FOR CRISIS MANAGEMENT

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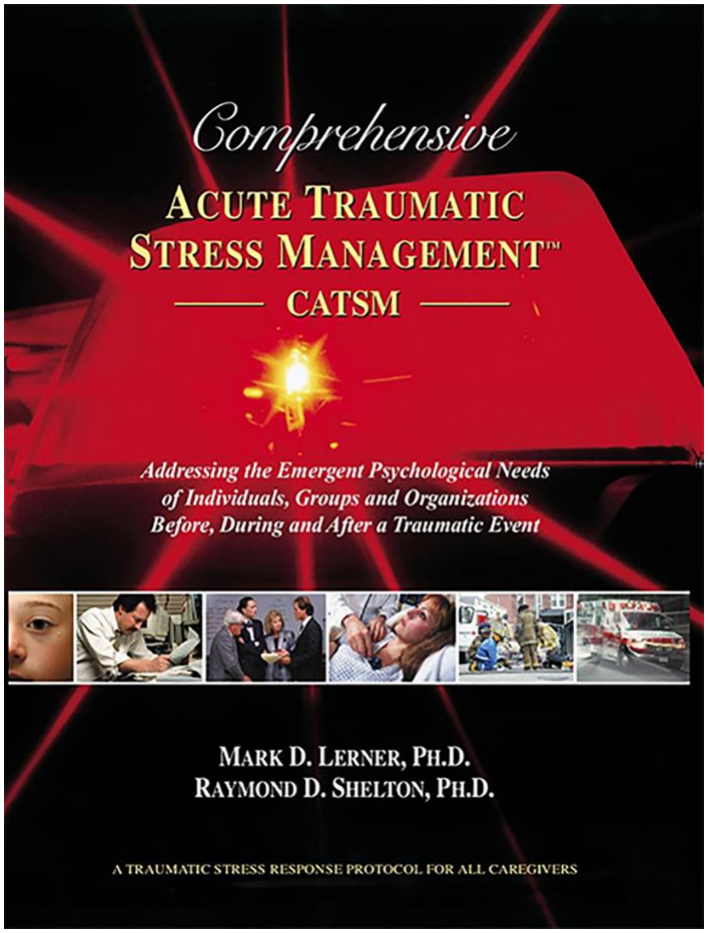
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During times of crisis, we are quick to address "physical trauma." We don't wait to call for help, and emergency medical personnel certainly don't wait to transport someone to the hospital before efforts are made to control bleeding. Unfortunately, a "hidden trauma" is often ignored. This trauma leaves the deepest scars and changes people forever—traumatic stress.

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JOSEPH "PAUL" MANLEY, M.A.



Joseph "Paul" Manley, M.A., is an independent risk and crisis-management consultant, educator, and author with more than 35 years of experience across law enforcement, public safety, corrections, investigations, crisis response, peer support, and organizational risk management. He is the Founder and Principal Consultant of Risk Mitigation Technologies LLC, where he advises organizations and leaders on behavioral risk, threat assessment, workplace violence prevention, high-stakes communication, and defensible decision-making under uncertainty.

Manley is a Board-Certified Workplace Violence & Threat Specialist, Diplomate of the National Center for Crisis Management, and Certified in Emergency Crisis Responder. He is trained in Acute Traumatic Stress Management and provides peer support and assistance to individuals experiencing acute traumatic stress following critical incidents and other distressing events.

His interest in traumatic stress and peer support extends to his graduate education. His M.A. capstone, *Does the Nahant Police Department Need a Stress Unit?* examined occupational stress within a municipal police department and explored the need for a formal organizational stress-support capability, including the potential role of peer support and resources following critical incidents.

As a member of the International Public Safety Association (IPSA), Manley also served as Project Manager and co-author of the 2018 *First Responder Line of Duty Death Causes and Prevention Strategies* report. The international research examined causes associated with line-of-duty deaths among first responders using information from the United States, Canada, and other countries and identified prevention strategies intended to reduce risk and improve first-responder safety.

His professional approach integrates trauma-informed practices, early recognition of behavioral and stress-related concerns, peer support, crisis management, and prevention-focused decision-making. He is particularly interested in helping individuals and organizations recognize concerns early, respond appropriately, and reduce the potential for a crisis to escalate.

Manley holds a Master of Arts in Criminal Justice Administration and has served as adjunct faculty teaching criminal justice, behavioral sciences, and security studies. He is an active member of the International Association of Professional Security Consultants (IAPSC), where he serves as Chair of the Membership Committee.

His writing and professional work have addressed traumatic stress, peer support, first-responder safety, trauma-informed approaches to workplace violence prevention, crisis management, behavioral risk recognition, and leadership decision-making. Click here to view Mr. Manley's workshops and presentations.

IRIT FELSEN, PhD



Irit Felsen, PhD is a clinical psychologist whose clinical work and research focus on trauma, resilience and intergenerational transmission. She is an Adjunct Professor at Columbia University and was an Assistant Professor at the Ferkauf Graduate School of Psychology, Yeshiva University for 14 years. Dr. Felsen is a Fellow of APA Trauma Division and a member of the American Academy of Experts in Traumatic Stress. She is chair of the Trauma Working Group at the NGO Committee on Mental Health in Consultative Relationship to the United Nations. During the Covid-19 pandemic, she chaired the Working Group on Older Adults in the APA Interdivision Covid-19 Task Force. The work of the various working groups was described in the 2023 book "Pandemic Providers" (Figley, Walker and Serlin, Eds.). She was a PI at Yale University in a study of trauma and psychosis, later published as a book, "Psychoanalysis and Holocaust Testimonies: Unwanted Memories of Social Trauma" (2017). Dr. Felsen's papers have been published in peer-reviewed professional journals, and she contributed multiple book chapters. Dr. Felsen is a sought-after speaker presenting nationally and internationally.

Dr. Felsen recently published an article entitled *Responses of Offspring of Holocaust Survivors to Antisemitism Today* in *Psychological Trauma: Theory, Research, Practice, Policy*. The following is a summary of the study as published online at https://link.growkudos.com/1ek87cng0zk.

This study examines how the historical trauma experienced by Holocaust survivors may influence the psychological well-being of their descendants today. It focuses on the psychological impact of the October 7, 2023, attacks and the subsequent rise in antisemitism in North America. The findings indicate that descendants whose parents experienced the Holocaust and had probable PTSD reported higher levels of PTSD symptoms than participants whose parents had not experienced the Holocaust. The results support the possibility that unresolved effects of historical trauma can create a latent vulnerability to distress, which is exacerbated when later events evoke reminders of the original trauma.

Understanding the psychological effects of historical trauma is important because its impact may extend beyond the generation that directly experienced it. Contemporary events, including terrorism, war, and antisemitism, may reactivate painful historical memories and feelings of threat among descendants of survivors. These findings highlight the importance of considering family history, collective trauma, and present-day social experiences when assessing psychological distress. Greater awareness of these connections may help mental health professionals provide more informed, sensitive, and individualized care to people affected by historical and intergenerational trauma. The intergenerational reverberations of collective trauma may render significantly large groups vulnerable to current stressors, highlighting the importance of this issue not only as an individual challenge but as a public health threat.

MEREDITH B. MORAN, Ed.D., LMHC, CCTP



Dr. Meredith Moran served as a police officer with the Largo Police Department in Florida from 1993 to 1999. That experience shaped a career devoted to the mental health of those who serve. She is the founder of Front Line Wellness, a private practice specializing in trauma treatment for first responders, military members, and veterans. She has more than 20 years of clinical experience, and her doctoral research focused on police officer stress and occupational trauma.

Dr. Moran has been affiliated with Critical Incident Stress Management of West Central Florida since 1999 and currently serves as its Clinical Director. She consults with fire departments across Pinellas County, Florida. Her clinical work integrates Accelerated Resolution Therapy (ART), EMDR, and somatic approaches within a trauma-informed framework. She practices alongside Gilbert, her certified therapy dog.

She is the author of The Daily Debrief: A 5-Minute Guided Journal for First Responders and Holding the Line at Home: A 30-Day Companion for the Spouses, Partners, Parents And Families of First Responders.

JOSE J. CALDERON, C. S. C. R.

Jose John Calderon is a retired law enforcement professional, educator, instructor, writer, and lifelong student of human behavior, leadership, service, and the complicated spaces where people and institutions meet. His professional life spans law enforcement, investigations, crisis intervention, de-escalation, training, education, and community service. He holds two bachelor's degrees, one in Spanish Language and another in History, academic foundations that fuel his analytical approach to historical and cultural context. Jose continues to write, teach, learn, and serve. He lives with his family in the Midwest and views himself not as some revered, all wise one, but simply as a mutual traveler, serving dual roles as both a student and a teacher of life.

Publications & Current Projects:

- Book: Take Heed — The Wisdom of De-Escalation (2026)
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- Notable Article: “The Quiet Work Within” (Published via LinkedIn) – Focusing on the deeper, universal journey of navigating life and internal change.

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CLARITY BEFORE CRISIS: BEHAVIORAL RISK RECOGNITION, LEADERSHIP DECISION-MAKING, AND TRAUMATIC STRESS IN THE WORKPLACE

JOSEPH PAUL MANLEY
RISK MITIGATION TECHNOLOGIES LLC

ABSTRACT

Workplace-crisis scholarship frequently emphasizes response and recovery, whereas the organizational period preceding an overt crisis has received less focused attention. During this pre-crisis period, behavioral concerns emerge, information remains incomplete, and leaders must determine whether and how to respond. This window presents an opportunity for recognition, assessment, and informed decision-making. Workplace violence is associated with psychological and organizational consequences, including distress, anxiety, depression, burnout, sleep disturbance, and post-traumatic stress symptoms. Contemporary crisis-management literature identifies early signal detection, risk management, prevention, and preparedness as elements of organizational crisis readiness. Threat-assessment literature similarly emphasizes contextual information gathering, assessment, intervention, and case management rather than relying on a single behavior or statement as a prediction of future violence.

This article places behavioral-risk recognition within a broader organizational crisis-management continuum and introduces a leadership decision framework organized around three questions: What do we know? What do we not know? What decisions need to be made now? By separating recognition from prediction, the framework directs leaders toward contextual assessment, proportionate action, and reassessment while acknowledging the limits of behavioral prediction. A composite case illustrates how the framework organizes structured information gathering, multidisciplinary assessment, proportionate intervention, and reassessment. The article argues that trauma-informed crisis management should address not only post-incident response but also pre-crisis opportunities to recognize developing concerns, reduce uncertainty, and support informed leadership decisions.

Keywords: workplace violence, traumatic stress, crisis management, behavioral risk, threat assessment, organizational resilience, crisis prevention, leadership decision-making

Introduction

When a workplace crisis occurs, organizational attention naturally turns toward immediate response: protecting people, stabilizing the environment, communicating with employees, coordinating resources, and addressing consequences. Yet another period of organizational decision-making deserves greater attention—the period before the crisis becomes obvious.

A workplace concern may begin with a change in behavior, a conflict, an alarming communication, or a pattern of disruptive incidents. Leaders often face incomplete information and competing explanations. The challenge is not simply recognizing that something is concerning; the challenge is determining what the organization should do with that information.

THE PRE-CRISIS WINDOW

For purposes of this article, the pre-crisis window is defined as the period in which a concern has become observable, but its meaning, severity, and appropriate organizational response remain uncertain. It begins when behavioral information warrants attention and continues while leaders gather context, evaluate competing explanations, determine whether intervention is necessary, and monitor changes in the situation.

Björck, Bläse, and Bastida conducted a systematic review of organizational crisis-readiness literature, screening 7,287 articles and identifying 40 eligible studies published between 1987 and 2022. Their synthesis identified crisis prevention, risk management, preparedness, and early signal detection among the elements associated with organizational crisis readiness (Björck et al., 2024).

Early signals rarely announce themselves as crises. They may appear to be isolated incidents, interpersonal conflicts, performance problems, or reactions to stress, dissatisfaction, organizational change, or personal circumstances. Any of those explanations may be correct; the difficulty is that leaders often cannot determine which explanation fits when the concern first emerges.

This creates a period of uncertainty.

A leader who reacts to every concerning behavior as though a serious threat is imminent risks unnecessary escalation, inappropriate intervention, and potentially harmful assumptions.

A leader who dismisses every concern until a threat becomes unmistakable may lose opportunities for earlier intervention.
Neither extreme represents effective risk management. The more useful question is: What information does leadership need, and what decision needs to be made now?

BEHAVIORAL RISK RECOGNITION IS NOT PREDICTION

Behavioral-risk recognition is sometimes misunderstood as an attempt to predict future violence. That is not an appropriate characterization of contemporary threat-assessment practice.

The threat-assessment model described by Fein, Vossekuil, and Holden emphasizes gathering information, examining circumstances, assessing the subject and potential target, and developing a case-management strategy. Their model recognizes that communicated threats may have different meanings depending on the circumstances and that assessment must move beyond the words themselves (Fein et al., 1995).

The distinction matters.

Prediction asks: Will this person become violent?
Recognition asks: What has changed, what information is available, and what circumstances require attention?

> Assessment asks: What might the available information mean when considered in context?
>
> Decision-making asks: What action, if any, is appropriate given what is currently known?

These are fundamentally different questions.

Research concerning warning behaviors provides another useful distinction. Meloy and colleagues describe warning behaviors as acute and dynamic changes in behavior that may contribute to professional judgment that risk is increasing or accelerating. Their typology was intended as an aid to threat assessment, not as a deterministic list of behaviors that predicts violence (Meloy et al., 2012).

Behavioral assessment operates under uncertainty because the same observable conduct may support several explanations. A communicated threat may express anger without intent or capability, while a seemingly minor event may become significant when considered alongside other information. Conversely, an isolated incident may remain just that. Recognition should therefore identify information that warrants further inquiry rather than attach a label to an individual.

FROM INCIDENT TO PATTERN

Behavioral information often enters an organization through separate channels: a supervisor receives one complaint, Human Resources receives another, security documents an incident, an employee-assistance professional holds relevant information within applicable confidentiality boundaries, or law enforcement becomes involved after a separate event. No single report may justify significant concern, yet the combined information may reveal a materially different pattern.

Recent research involving the Veterans Health Administration provides a contemporary example. The

VA developed a Workplace Behavioral Risk Assessment system that collects behavioral-threat information from multiple systems and consolidates the information for analysis. The system was developed in 2012 and has been used across VA healthcare systems; a 2026 publication examined data associated with 140 VA healthcare systems and described multidisciplinary review and the use of aggregated behavioral information to inform training and risk management (Vance et al., 2026).

The significance of this work is not that every organization should reproduce the VA system.

Rather, it demonstrates an important organizational principle: Information that remains isolated may be difficult to interpret. Information considered in context may reveal a pattern.

Pattern recognition does not mean assuming that a pattern guarantees violence. It means recognizing that context matters.

THE LEADERSHIP DECISION POINT

There is a point at which leadership must decide whether a concern warrants further assessment.
This article refers to the point at which leaders determine whether a concern warrants further assessment as the Leadership Decision Point. The term describes a decision-making juncture rather than a discrete or empirically validated threshold.

At this point, leaders should be able to ask three fundamental questions:

> What do we know? What has actually been observed, reported, documented, or reliably established?
>
> What do we not know? What information is missing? What assumptions are being made? Are there competing explanations?
>
> What decisions need to be made now? What action is necessary at this point, given the information currently available?

These questions are deliberately simple because they are intended to discipline leadership judgment, not replace professional assessment. They do not constitute a validated clinical instrument or threat-assessment protocol. Instead, they prevent organizations from moving directly from concern to conclusion by requiring leaders to separate established facts, unresolved uncertainties, and immediate decisions.

That distinction is particularly important because leadership decisions can themselves influence the trajectory of a workplace concern.

An organization may need to gather additional information. It may need to address an interpersonal conflict. It may need to involve Human Resources. It may need to consult an employee-assistance program or other support resource. It may need a formal behavioral threat assessment. It may need additional security measures. In an emergency, it may need immediate protective action.

The appropriate response depends on the circumstances. The goal is not maximal intervention. The goal is proportionate, informed intervention.

AN APPLIED LEADERSHIP FRAMEWORK

A practical framework for moving from behavioral concern toward informed organizational action can be expressed as:

Recognition → Assessment → Decision → Action → Reassessment

RECOGNITION

Identify the behavior, incident, communication, or pattern that has generated concern. Recognition requires attention to observable information rather than assumptions about personality, diagnosis, motive, or future behavior.

ASSESSMENT

Examine the available information in context. What happened? What circumstances surround the behavior? What information supports the concern? What information may contradict or qualify it? What information is missing?

DECISION

Determine what leadership needs to decide at the present time. Not every concern requires the same response. The decision may be to gather additional information, engage appropriate organizational resources, address a workplace condition, conduct a formal assessment, implement safeguards, or take emergency action.

ACTION

Implement the response appropriate to the circumstances. Action should be proportionate to the available information and organizational responsibilities.

REASSESSMENT

Risk is not static. Circumstances change. New information may emerge. Behavior may escalate, stabilize, or resolve. Consequently, an assessment made at one point in time should not necessarily be treated as permanent. This final step transforms assessment from a one-time event into an ongoing management process. The framework is most useful when it guides process rather than labels people. Organizations should apply it through established reporting, assessment, legal, privacy, and emergency-response procedures, with appropriately qualified professionals involved when circumstances warrant. Immediate threats or emergencies require protective action and should not be delayed by deliberative use of the framework.

AN ILLUSTRATIVE COMPOSITE CASE

The following fictional composite was created for educational purposes and does not describe a specific client, employer, employee, or incident. It combines recurring workplace-risk circumstances to illustrate the decision-making process presented in this article.

A mid-sized organization receives a report concerning an employee who has recently become increasingly confrontational with supervisors. Initially, the matter appears to be an employee-relations problem. Over several weeks, three separate incidents are reported.

In the first, the employee becomes visibly angry during a performance discussion and states that management will "regret what they've done."

In the second, a coworker reports that the employee has begun repeatedly discussing perceived injustices involving management and has become increasingly preoccupied with a workplace dispute.

In the third, the employee sends a lengthy communication to several members of leadership challenging prior employment decisions and stating that the organization has "pushed this too far."

No individual incident establishes that violence is imminent: leadership has no confirmed information about a weapon, no explicit statement of intent to attack anyone, and no evidence that an assault is about to occur. The concern arises instead from the accumulation and apparent escalation of the incidents. Leadership must therefore decide whether the matter remains solely an employee-relations issue or whether the pattern now warrants structured assessment.

The Leadership Decision Point provides a useful way to frame the problem.

What do we know? Leadership knows that there has been a pattern of escalating conflict, increasingly hostile communications, repeated references to perceived injustice, and a change in the employee's interaction with supervisors and coworkers.

What do we not know? Leadership does not yet know whether the behavior represents transient anger, an unresolved employment dispute, a broader deterioration in functioning, or a developing pathway toward violence. Nor does leadership know whether other relevant incidents have occurred that have not reached management.

What decisions need to be made now? Leadership must determine whether additional information should be gathered, whether a multidisciplinary assessment is warranted, whether workplace conditions require intervention, whether safety measures are appropriate, and whether support resources should be offered.

The organization decides to document the known incidents, review relevant information within applicable legal and privacy boundaries, consult appropriate Human Resources and security personnel, and obtain a formal threat assessment.

The assessment does not conclude that violence is inevitable. Instead, it identifies several factors requiring continued management: escalating grievance behavior, increasing fixation on perceived injustice, deterioration in workplace relationships, and increasingly concerning communications.

The organization develops a proportionate management plan. That plan includes clearly communicating behavioral expectations, establishing a designated management contact, coordinating appropriate organizational resources, reviewing workplace access and safety considerations, and establishing criteria for reassessment should behavior change.

Several weeks later, the employee's communications become less hostile and the workplace conflict begins to stabilize. The case is not declared "solved." It is reassessed.

This fictional example illustrates how the framework can organize information and decisions under uncertainty. It does not demonstrate that the framework predicts outcomes or causes stabilization. Its value is analytic: it shows how early recognition may create an opportunity for structured decision-making before an organization must respond to an emergency.

PROPORTIONATE INTERVENTION

One potential danger in discussions of workplace violence prevention is the tendency to view intervention as synonymous with removal, discipline, or termination.

Threat-management research does not support such a simplistic approach.

Peek-Asa and colleagues examined workplace violence investigations conducted by a large multinational corporation during 2009 and 2010. Cases in which a Threat Management Team was activated were more likely to result in corrective action and Employee Assistance Program referral, but activation was not associated with an increased likelihood of termination (Peek-Asa et al., 2013).

These findings suggest that multidisciplinary threat-management involvement may support a wider range of organizational responses than termination alone. Because the study examined investigations within one multinational corporation during a limited period, however, it does not establish that similar outcomes will occur across organizations or settings.

Threat assessment is not primarily a mechanism for deciding who should be removed; it is a process for understanding a situation well enough to choose an appropriate response. Depending on the circumstances, that response may combine support, workplace problem-solving, behavioral expectations, administrative action, security measures, clinical resources, or law-enforcement involvement. The organization does not need certainty about the future to make a proportionate decision in the present.

CONNECTING PREVENTION TO TRAUMATIC STRESS

The relevance of this framework to traumatic stress lies in the consequences of workplace violence, which can extend beyond an immediate physical event.
The National Institute for Occupational Safety and Health describes workplace violence as ranging from verbal abuse and threats to physical assault and notes that workplace violence can have long-term physical and psychological effects (NIOSH, 2024).

OSHA likewise recognizes that threats, abuse, hostility, harassment, and other forms of verbal violence can produce psychological trauma and stress even when no physical injury occurs.

The research literature provides additional support.

Rudkjoebing and colleagues' systematic review and meta-analysis found associations between work-related violence or threats and depression, anxiety symptoms, burnout, psychological distress, and sleep disturbance, while noting important methodological limitations (Rudkjoebing et al., 2020).

Wang and colleagues' meta-analysis found that nurses exposed to workplace violence had higher odds of reporting PTSD and burnout than those without such exposure (Wang et al., 2022).

Hilton and colleagues' systematic review of psychiatric nurses identified severe or injurious assault and cumulative exposure as promising PTSD risk factors and

concluded that violence prevention and mental-health care for exposed nurses were among the most promising targets for PTSD prevention (Hilton et al., 2022).

Taken together, these findings support concern about the psychological consequences associated with workplace violence, although they do not establish that every exposure produces traumatic stress or that earlier behavioral-risk recognition prevents PTSD. They nevertheless provide a rationale for examining reduction of avoidable exposure as one component of a broader organizational strategy to protect employee well-being.

PREVENTION WITHOUT OVERPROMISING

It is important not to overstate the evidence supporting workplace-violence prevention.

A systematic review and meta-analysis by Abeyta and Welsh identified only 10 studies meeting its inclusion criteria. The authors found that employee- and organizational-level interventions showed positive but statistically nonsignificant pooled effects and emphasized substantial variation among intervention approaches and the need for additional research (Abeyta & Welsh, 2022).

This limitation is important. The evidence does not support the proposition that any single prevention framework will prevent all workplace violence. Instead, the evidence supports a broader approach involving organizational preparedness, risk identification, appropriate intervention, worker support, and continuing evaluation.

OSHA's workplace-violence guidance similarly treats prevention as a comprehensive organizational responsibility rather than a single training event or security measure.

A prevention-focused approach should therefore be understood as an opportunity to improve organizational readiness—not as a guarantee of prevention.

THE PREVENTION–CRISIS–RECOVERY CONTINUUM

A comprehensive approach to workplace crisis management can be conceptualized as a continuum with three phases.

Before the crisis: Behavioral concern → Recognition → Information gathering → Assessment → Leadership Decision Point → Proportionate intervention → Reassessment.

During the crisis: Protection → Emergency response → Stabilization → Communication.

After the crisis: Psychological support → Recovery → Organizational learning → Reassessment.

The continuum assigns distinct responsibilities to each phase of a workplace crisis. Before a crisis, organizations recognize concerns, gather information, assess context, make proportionate decisions, and reassess. During a crisis, priorities shift to protection, emergency response, stabilization, and communication. Afterward, psychological support, recovery, organizational learning, and continued reassessment become central. The phases are connected: information and lessons from one phase should improve readiness for the next.

IMPLICATIONS FOR ORGANIZATIONAL LEADERS

A prevention-focused approach requires leaders to reconsider what they do with early information.

Organizations can operationalize a prevention-focused approach by establishing clear processes for reporting and documenting concerning behavior; defining responsibilities among leadership, Human Resources, security, employee-assistance resources, legal counsel, and other relevant professionals; specifying when additional assessment is warranted; distinguishing observable behavior from interpretation; and reassessing concerns when circumstances change. These processes must operate within applicable legal, ethical, privacy, employment, and confidentiality requirements.

The objective should not be to create an organization in which every unusual behavior becomes a security case. The objective should be to create an organization in which meaningful concerns are neither automatically

escalated nor prematurely dismissed. That requires judgment. It requires context. And it requires leadership.

A PRACTICAL QUESTION FOR LEADERS

Rather than asking, "Is this person dangerous?" leaders should ask, "What do we know, what remains uncertain, and what decision must be made now?" The first question invites an unsupported label; the second directs attention to evidence, information gaps, immediate responsibilities, and the need for reassessment. It creates a path from awareness to proportionate action without assuming that the outcome is predetermined.

LIMITATIONS

A prevention-focused approach must acknowledge its limitations.

Behavioral assessment cannot reliably predict every act of workplace violence. Not every concerning behavior represents an increased risk of violence. Some individuals who engage in concerning behavior will never become violent. Some violent incidents may occur with little observable warning.

Organizational decision-making is also influenced by the quality and availability of information, the competence of those conducting assessments, organizational culture, available resources, legal requirements, and the specific circumstances of each case.

The evidence concerning workplace-violence prevention interventions remains heterogeneous. Abeyta and Welsh found only 10 studies meeting their inclusion criteria in their systematic review and meta-analysis, with pooled effects that did not reach statistical significance (Abeyta & Welsh, 2022).

Accordingly, the framework presented here should be understood as a conceptually derived leadership heuristic rather than a validated predictive or decision instrument. Its elements are informed by crisis-readiness, threat-assessment, workplace-violence, and traumatic-stress literature, but the framework itself has not been empirically tested. It should not substitute for established threat-assessment, clinical, legal, emergency-response, or organizational procedures.

It is a leadership framework for thinking about the period before a crisis.

The framework yields several propositions that can be examined empirically. Organizations using structured cross-functional information review may identify relevant patterns earlier than organizations relying on isolated reporting channels. Use of the three-question heuristic may also improve documentation of known facts, uncertainties, and immediate decisions. Future research should assess whether these processes improve decision quality, timeliness, proportionality, employee trust, and safety outcomes, as well as whether they produce unintended effects such as over-reporting, stigmatization, or unnecessary escalation.

CONCLUSION

Workplace crises are often defined by the moment when uncertainty gives way to an unmistakable event. But organizational responsibility does not necessarily begin at that moment. There may be an earlier period in which behavior changes, concerns emerge, information accumulates, and decisions become necessary. That period deserves greater attention.
The objective of early behavioral-risk recognition is not to predict the future. It is to improve the quality of decisions in the present.

For organizations concerned with workplace violence, crisis management, and traumatic stress, this means expanding the concept of prevention beyond policies, physical safeguards, and post-incident response.

Prevention can also involve recognizing meaningful concerns early, gathering relevant information, challenging assumptions, assessing circumstances, making proportionate decisions, and remaining willing to reassess as information changes.

The proposed Clarity Before Crisis framework extends trauma-informed crisis management to the pre-crisis window, during which organizations may recognize meaningful concerns, reduce uncertainty, make proportionate decisions, and reassess as circumstances change. Its central premise is that organizations can improve present decision-making without claiming certainty about future behavior.

In this formulation, recognition informs decision-making, decisions guide proportionate action, and proportionate action may strengthen organizational prevention and preparedness.

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INTEGRATING TRAUMA AND ADDICTION TREATMENT THROUGH A SALUTOGENIC LENS: THE FORWARD-FACING® ACCELERATED RECOVERY APPROACH FOR TRAUMADDICTION®

J. ERIC GENTRY, PhD, AND LINDSAY ROTHSCHILD, LCSW

ABSTRACT

Substance use disorders (SUDs), addictive behaviors, and trauma-related conditions frequently co-occur, yet treatment is not always integrated. Addiction care has historically emphasized stabilization, abstinence, and relapse prevention, sometimes without adequately addressing posttraumatic stress. This separation may undermine recovery when trauma-related distress, craving, and substance use remain mutually reinforcing.

The Forward-Facing® Accelerated Recovery (FF-AR) model offers an integrative, salutogenic framework for addressing trauma and addiction simultaneously. It conceptualizes addictive behavior as an adaptive response to overwhelming internal states rather than solely as pathology. Instead of positioning intensive memory processing as the universal entry point, FF-AR emphasizes neuroception, interoceptive awareness, acute regulation skills, and gradual expansion of capacity (Gerge, 2020). These elements are intended to support engagement in trauma-focused and addiction-focused treatment without exceeding the individual's tolerance.

FF-AR is grounded in Antonovsky's (1979, 1987) Sense of Coherence, comprising comprehensibility, manageability, and meaningfulness. The model operationalizes these dimensions by helping individuals understand internal experiences, develop practical regulation resources, and reconnect with purpose, values, and forward movement. Recovery is therefore conceptualized as both symptom reduction and capacity development.

This paper presents the model's theoretical foundations, clinical applications, and emerging practice-based evidence. Because controlled research on FF-AR remains limited, its clinical propositions are distinguished from the broader evidence supporting integrated PTSD/SUD treatment, associative learning, interoception, therapeutic alliance, and salutogenesis. Preliminary program-evaluation data from Seven Arrows Recovery, where FF-AR has been used since 2023, suggest improvements in posttraumatic symptoms, resilience, intentionality, and quality of life; however, these unpublished findings are hypothesis-generating rather than evidence of efficacy.

KEY WORDS: TraumAddiction, Posttraumatic Stress Disorder (PTSD), Substance Use Disorders (SUD), Co-Occurring Disorders, Salutogenic, Forward-Facing®

BACKGROUND AND HISTORICAL CONTEXT

Trauma and addiction have historically been treated as separate behavioral-health domains, resulting in fragmented care for many people with co-occurring conditions. Early work by Evans and Sullivan (1995) and Najavits (2002) emphasized integrated approaches, yet treatment systems have often continued to operate in parallel: substance use treatment prioritizing stabilization and relapse prevention, and trauma treatment emphasizing trauma-focused cognitive, exposure, or memory-processing interventions. This division contributed to a longstanding clinical tension regarding when and how to address trauma during recovery.

Contemporary evidence does not support a universal requirement that individuals achieve prolonged abstinence before receiving trauma-focused care. Meta-analyses and expert recommendations indicate

that trauma-focused interventions can be delivered concurrently with SUD treatment for appropriately assessed patients, with individualized attention to safety, withdrawal status, readiness, pacing, and monitoring (Hien et al., 2024; Roberts et al., 2023; Simpson et al., 2021). In a recent treatment-seeking SUD sample, 40.6% screened positive for ICD-11 PTSD or complex PTSD, with complex PTSD substantially more prevalent than PTSD (Harvey et al., 2026). At the same time, acute intoxication or withdrawal, severe instability, limited coping capacity, or rapidly escalating craving may warrant additional supports or slower progression rather than automatic exclusion from trauma-focused treatment.

Conversely, sequential models have sometimes deferred trauma treatment until sustained abstinence is achieved. Although this may be clinically appropriate for some individuals, prolonged deferral can leave trauma-related distress untreated. Current reviews favor integrated or concurrent treatment, while emphasizing collaborative case formulation and individualized sequencing rather than a single rule for all patients (Hien et al., 2024; Roberts et al., 2023; Simpson et al., 2021).

Many individuals in substance use treatment present with clinically significant posttraumatic symptoms, including subthreshold and complex presentations, whether or not they meet full criteria for a specific trauma-related diagnosis. Complex presentations may include affective dysregulation, relational disturbance, and negative self-concept in addition to core PTSD symptoms (Harvey et al., 2026). These findings highlight the limitations of strictly diagnosis-driven formulations and support dimensional, non-pathologizing approaches that attend to trauma-related adaptations while preserving diagnostic precision.

Broader conceptualizations of adversity—including adverse childhood experiences (ACEs), adverse life experiences (ALEs), developmental and relational trauma, institutional adversity, and possible intergenerational pathways—further emphasize the relevance of cumulative stress in SUD. The original ACE study and subsequent meta-analytic evidence demonstrate graded associations between childhood adversity and substance use outcomes (Felitti et al., 1998; Zhu et al., 2025). Stress and addiction research also implicates interacting systems involved in arousal, executive control, reward, and interoceptive processing (Koob & Volkow, 2016; Sinha, 2008; Verdejo-Garcia et al., 2012). In this paper, ALE is used as a broad clinical construct rather than a universally standardized diagnostic category.

These limitations support an integrated, capacity-sensitive approach that addresses trauma and addiction together without treating stabilization and processing as mutually exclusive. FF-AR emerges within this context as a model that prioritizes nervous-system regulation, self-development, and gradual expansion of capacity while remaining compatible with concurrent evidence-based PTSD/SUD treatment.

ADDICTION AS A POST-TRAUMATIC ADAPTATION

The original ACE study demonstrated a graded relationship between cumulative childhood adversity and later health-risk behaviors, including alcohol and drug problems (Felitti et al., 1998). A recent meta-analysis likewise found significant associations between ACE exposure and multiple forms of substance use, although effect sizes varied by substance and study characteristics (Zhu et al., 2025). These findings support a dose-response formulation without reducing an individual's risk or prognosis to a single ACE score.

Addiction can be conceptualized, in part, as a functional adaptation used to regulate overwhelming emotional and physiological states. Substance use and other compulsive strategies may provide short-term relief through numbing, avoidance, dissociation, reward, or modulation of arousal. Trauma and chronic stress are associated with alterations in interoceptive processing, stress responsivity, and executive functioning, while addiction involves neurocircuitry related to reward, salience, stress, and inhibitory control (Arnsten, 2009; Goldstein & Volkow, 2011; Koob & Volkow, 2016; Schulz & Vögele, 2015; Verdejo-Garcia et al., 2012). Under acute stress, prefrontal functions supporting working memory, inhibition, and flexible decision-making may become less available (Arnsten, 2009).

Within this formulation, avoidance behaviors and addictive strategies are understood not as character deficits but as learned, survival-oriented attempts to manage distress. This perspective does not minimize the harms or loss of control associated with SUD; rather, it places those behaviors within a functional analysis of

what they accomplish in the short term and what maintains them over time (Koob & Volkow, 2016; Sinha, 2008).

Accordingly, FF-AR emphasizes the development of resources and regulation capacity before and alongside more activating trauma work. This is a model-specific sequencing principle, not a claim that all trauma processing must be delayed. Current guidance supports concurrent PTSD/SUD treatment when the individual can participate safely, with readiness determined through collaborative assessment rather than abstinence duration alone (Hien et al., 2024; Roberts et al., 2023).

SALUTOGENIC SOLUTIONS

Salutogenesis, introduced by Aaron Antonovsky (1979), shifts attention from the causes of disease toward the processes and resources that support health. Central to this model is Sense of Coherence (SOC), which Antonovsky later defined as:

> A global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that: (1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable, and explicable (comprehensibility); (2) the resources are available to one to meet the demands posed by these stimuli (manageability); and (3) these demands are challenges, worthy of investment and engagement (meaningfulness). (Antonovsky, 1987, p. 19)

FF-AR operationalizes these salutogenic principles through three corresponding domains. Research on SOC generally supports its association with perceived health and quality of life, while not establishing that SOC alone causes clinical improvement (Eriksson & Lindström, 2006).

Comprehensibility. Within this domain, FF-AR emphasizes a coherent understanding of autonomic activation, threat appraisal, craving, and behavioral response. Clients learn to notice and interrupt escalating activation. Reducing acute arousal may improve comfort and access to intentional responding, although claims of immediate or complete restoration of cognitive or motor functioning would exceed the current evidence (Arnsten, 2009).

Within this framework, urges and cravings can be understood through an intrusion-arousal-avoidance cycle, reframing addictive behavior as a predictable learned response to distress rather than a failure of willpower. FF-AR proposes that this functional reframing may reduce shame and support self-compassion; direct study of this mechanism within FF-AR is needed.

Manageability. FF-AR cultivates manageability through the integration of neuroception, interoception, and acute relaxation strategies. Neuroception is Porges's theoretical term for the nervous system's implicit evaluation of safety and threat (Porges, 2004). Interoception refers to the sensing and interpretation of internal bodily signals and is increasingly relevant to stress and addiction research (Schulz & Vögele, 2015; Verdejo-Garcia et al., 2012). Through coaching and repeated practice, clients learn to differentiate current danger from conditioned or anticipated threat, notice early physiological activation, apply regulation skills, and choose a response with greater deliberation.

Meaningfulness. Meaningfulness is a central component of Antonovsky's SOC and may shape how individuals understand and engage with the demands of recovery (Antonovsky, 1987; Eriksson & Lindström, 2006). When treatment is experienced as personally relevant and connected to values, identity, and purpose, clients may be better able to tolerate difficulty and integrate change beyond the clinical setting.

Without personally meaningful goals, even technically sound interventions may feel disconnected from the individual's life. FF-AR therefore treats meaning-making as a clinical resource rather than assuming that symptom reduction alone will produce sustained recovery.

FF-AR cultivates personal meaning through development of a code of honor, mission statement, and vision for life and recovery. The emphasis is on intentional, values-guided living and on approaching life's challenges as worthy of sustained engagement.

NEUROBIOLOGICAL CONDITIONING AND THE CENTRAL ROLE OF AUTONOMIC NERVOUS SYSTEM REGULATION

Traumatic learning can involve associative processes in which internal or external cues become linked with

intense physiological and emotional responses. Later encounters with similar cues may activate learned threat expectations and defensive responding even when objective danger is absent. Contemporary exposure models conceptualize improvement primarily through new inhibitory or corrective learning rather than literal erasure of the original memory association (Craske et al., 2014).

During intense stress or autonomic activation, prefrontal functions involved in working memory, impulse control, and flexible decision-making may be compromised (Arnsten, 2009). In addiction, stress-related processes interact with reward, salience, and inhibitory-control circuitry, increasing vulnerability to craving and habitual responding (Goldstein & Volkow, 2011; Koob & Volkow, 2016; Sinha, 2008). This supports the clinical value of regulation skills, while not implying that regulation alone is sufficient treatment for SUD or PTSD.

Chronic stress may be expressed through hyperarousal, emotional reactivity, avoidance, dissociation, or hypoarousal. Substances can function as short-term attempts to modulate these states, thereby reinforcing use despite longer-term harm (Koob & Volkow, 2016; Sinha, 2008). Polyvagal-informed formulations sometimes describe immobilization or shutdown through a dorsal-vagal framework (Porges, 2004); this language is best presented as a theoretical clinical formulation rather than a stand-alone diagnostic or fully established neuroanatomical explanation.

Reciprocal inhibition is a historical clinical concept describing the pairing of feared cues with an incompatible or regulated response. Contemporary exposure science more commonly emphasizes inhibitory learning: repeated, supported encounters can create new safety or coping associations that compete with prior threat expectations (Craske et al., 2014). The original association may remain and can re-emerge through renewal, reinstatement, or context change; therefore, extinction should not be described as guaranteed or complete. Within FF-AR, regulated engagement with activating cues is intended to strengthen corrective learning and reduce reliance on substances as external regulators, a mechanism that requires direct empirical testing.

ACTIVE INGREDIENTS APPROACH

The Active Ingredients Approach identifies therapeutic mechanisms that recur across trauma treatments, including the therapeutic relationship, positive expectancy, self-regulation, exposure, cognitive restructuring, psychoeducation, self-compassion, and reduction of shame (Gentry et al., 2017). FF-AR sequences these elements intentionally: relational safety and hope are established while regulation skills are developed, followed by increasingly demanding application. The therapeutic alliance is a robust, though not exclusive, correlate of psychotherapy outcome (Flückiger et al., 2018).

Subsequent phases emphasize applying skills in increasingly complex environments. Within FF-AR, clients engage with real-world challenges while practicing regulation, an in vivo strategy intended to promote inhibitory learning, generalization, and self-efficacy (Craske et al., 2014). Imaginal exposure or memory processing may also be introduced when clinically indicated and collaboratively selected. The FF-AR preference for beginning with in vivo application is a model-specific choice, not a universal evidence-based requirement.

This salutogenic progression reflects four phases: (1) preparation and therapeutic relationship, (2) psychoeducation and skills development, (3) integration and desensitization, and (4) posttraumatic growth and resilience. It is broadly consistent with phase-oriented principles emphasizing safety and capacity while also recognizing that contemporary PTSD/SUD guidance supports integrated trauma-focused treatment without requiring prolonged abstinence or completion of a fixed stabilization phase (Herman, 1992; Roberts et al., 2023).

In TraumAddiction treatment, FF-AR therefore prioritizes present-focused regulation during early recovery while continually reassessing readiness for trauma-focused work. Memory processing is introduced when clinically indicated, collaboratively chosen, and supported by adequate safety, attention, consent, and coping resources. This capacity-sensitive approach should complement—not replace—evidence-based SUD treatment, medication when indicated, withdrawal management, and validated trauma-focused interventions (Hien et al., 2024; Roberts et al., 2023; Simpson et al., 2021).

CLINICAL APPLICATIONS OF FORWARD-FACING ACCELERATED RECOVERY

Forward-Facing® Accelerated Recovery is designed for implementation across levels of care, including inpatient, residential, partial hospitalization, outpatient, and individual treatment. Its structure permits integration into existing services while preserving its core emphasis on comprehensibility, manageability, meaningfulness, and capacity-sensitive practice.

At the clinical level, FF-AR begins with a shift in case conceptualization. Addiction is framed as a potentially adaptive response to posttraumatic or other overwhelming states, and cravings, avoidance, or emotional numbing are examined functionally rather than interpreted solely as resistance. FF-AR hypothesizes that this reframing can reduce shame and defensiveness and improve engagement; these model-specific outcomes require formal evaluation.

Assessment within FF-AR considers both trauma history and current functioning. In addition to a standard biopsychosocial and SUD assessment, clinicians evaluate patterns of activation, dissociation, interoceptive awareness, craving, coping resources, suicide risk, withdrawal risk, and capacity for self-regulation. Longitudinal mapping and tools addressing ACEs, ALEs, or trauma responses may support formulation, but proprietary or locally developed instruments should not substitute for validated diagnostic, symptom, and risk measures.

Interventions within FF-AR are organized around four primary clinical modalities: psychoeducation, experiential skill building, in vivo application, and practices that support movement from reactive toward intentional living.

Psychoeducation develops a working understanding of autonomic activation, neuroception, interoception, acute relaxation, and the intrusion-arousal-avoidance cycle. Clients are invited to recognize craving and distress as understandable psychophysiological responses while retaining accountability for behavior. This supports SOC comprehensibility and may reduce self-blame (Antonovsky, 1987; Porges, 2004; Verdejo-Garcia et al., 2012).

Experiential skill building combines bottom-up and top-down strategies, including diaphragmatic breathing, body scanning, progressive muscle relaxation, grounding, attentional broadening, and cognitive labeling. Clients track internal states, identify early cues of dysregulation, and practice interventions in real time. These practices are intended to strengthen interoceptive discrimination and perceived manageability; evidence for individual techniques varies, and they should be integrated with established SUD and trauma treatments rather than presented as stand-alone cures (Schulz & Vögele, 2015; Verdejo-Garcia et al., 2012).

In vivo application is a defining FF-AR component. Clients engage with real-world triggers and stressors while attempting to maintain or restore a workable level of regulation—for example, during interpersonal conflict, community activities, or emotionally difficult situations. Such practice may support inhibitory learning, generalization, and self-efficacy (Craske et al., 2014). The proposition that repeated FF-AR practice reduces posttraumatic symptoms, obsession, compulsion, or urgency to use substances is clinically plausible but requires direct controlled study.

When FF-AR is delivered in groups, co-regulation, normalization, rehearsal, and shared learning can reinforce skill acquisition. Individual therapy, peer encounters, and milieu-based coaching can then tailor and generalize the skills. Because relationship quality contributes to outcome, group and individual delivery should emphasize attunement, collaboration, and repair of alliance ruptures (Flückiger et al., 2018).

Relapse prevention within FF-AR is conceptualized as regulation-informed rather than exclusively behavioral. Clients learn to identify physiological and contextual precursors to use and to intervene early with regulation, social support, medication or clinical contact when indicated, and established relapse-prevention strategies. FF-AR is intended to target one set of mechanisms contributing to addictive behavior while supporting purpose-based intentional living and interpersonal functioning.

FF-AR is consistent with trauma-informed and trauma-responsive principles of safety, choice, collaboration, trustworthiness, and empowerment. Interventions are invitational, and pacing is responsive to capacity and

context. Evidence regarding trauma-informed organizational care in substance use settings is promising but heterogeneous, with limitations in study quality; claims of improved outcomes should therefore remain appropriately qualified (Mahon, 2025).

PATHWAY TO HEALING: FORWARD-FACING ACCELERATED RECOVERY

The Forward-Facing® Accelerated Recovery model conceptualizes healing as a dynamic, capacity-based process involving nervous-system regulation, self-efficacy, relationship, and intentional living. Rather than defining success solely as symptom reduction, FF-AR emphasizes the individual's expanding ability to navigate internal and external experiences while remaining sufficiently regulated to act in accordance with recovery goals.

The pathway to healing within FF-AR embodies a Salutogenic Treatment Structure—a model-specific synthesis informed by Antonovsky's salutogenesis, phase-oriented trauma care, and the Active Ingredients framework (Antonovsky, 1987; Gentry et al., 2017; Herman, 1992). The progression is flexible rather than strictly linear, and individuals may revisit phases as demands and capacities change.

The first phase, Preparation and Therapeutic Relationship, centers on safety, trust, positive expectancy, and relational attunement. The therapeutic relationship supports engagement, hope, and co-regulation. Clinicians adopt a non-pathologizing stance, normalize understandable adaptations to adversity, and identify internal and external resources. This emphasis is consistent with evidence that the therapeutic alliance is reliably associated with psychotherapy outcomes (Flückiger et al., 2018).

The second phase, Psychoeducation and Skills Development, builds comprehensibility and manageability. Clients learn how threat, stress, craving, and habitual behavior can interact, while addiction is framed functionally rather than morally. In the authors' clinical experience, this reframing may reduce shame-based self-reference and support self-compassion; formal measurement of this proposed mechanism within FF-AR is needed.

Neuroception, interoception, and acute regulation skills are taught as practical tools for noticing and responding to activation. Repetition is emphasized because skill acquisition requires conceptual understanding and embodied practice. Successful regulation may increase comfort, perceived agency, and access to executive functions that are vulnerable under stress (Arnsten, 2009; Schulz & Vögele, 2015).

The third phase, Integration and Desensitization, pairs regulation skills with increasingly complex or activating contexts. FF-AR prioritizes in vivo practice to build generalizable coping and new inhibitory learning (Craske et al., 2014). The term extinction is used cautiously because new learning does not necessarily erase the original association and may remain context dependent.

Imaginal exposure or memory processing may be introduced selectively when clinically indicated, collaboratively selected, and supported by adequate readiness and safety. Within FF-AR, in vivo work is often used first; however, current evidence for co-occurring PTSD/SUD supports concurrent trauma-focused treatment and does not establish that in vivo exposure must precede imaginal or other trauma-focused methods in every case (Hien et al., 2024; Roberts et al., 2023; Simpson et al., 2021).

The final phase, Posttraumatic Growth and Resilience, emphasizes meaning, purpose, and forward movement. Clients develop a code of honor, mission statement, and life vision to support intentional living. This aligns with the SOC domain of meaningfulness. Posttraumatic growth has been described across five domains: relating to others, new possibilities, personal strength, spiritual change, and appreciation of life (Tedeschi & Calhoun, 1996). Growth should not be presumed, required, or used to minimize persistent suffering.

Ultimately, the FF-AR pathway supports movement from survival-dominated functioning toward intentional, values-guided living. It contrasts a narrow return-to-baseline goal with the possibility of growth beyond premorbid functioning, while recognizing that recovery trajectories are individualized and may include continuing symptoms, medication, mutual-help participation, and ongoing clinical care.

THE ROLE OF THE PROVIDER AND RELATIONAL DELIVERY OF FORWARD-FACING ® ACCELERATED RECOVERY

The effectiveness of FF-AR is proposed to depend not only on techniques but also on the presence, skill, and regulation of the person delivering care. Within this framework, provider includes licensed clinicians as well as appropriately trained and supervised peer-support specialists, behavioral-health technicians, and other direct-care staff. The model assumes that healing is strengthened through repeated relational experiences across the treatment environment.

Psychotherapy research identifies the therapeutic alliance as a robust contributor to outcome across approaches (Flückiger et al., 2018). FF-AR interprets relational attunement partly through co-regulation and Porges's neuroception construct: clients implicitly respond to interpersonal cues that may be experienced as safe or threatening (Porges, 2004). A grounded and responsive provider may support engagement and learning, but claims that provider regulation directly determines client neurophysiology should be framed as a clinical hypothesis rather than established causal fact. Relational safety develops through repeated experiences of attunement, consistency, responsiveness, and repair. For individuals with developmental or relational trauma histories, these experiences may be especially important. Within FF-AR, the provider serves as a stabilizing relational resource while clients navigate distress, activation, or craving, consistent with the broader importance of therapeutic alliance (Flückiger et al., 2018).

FF-AR is intended for use beyond the traditional therapy hour. Residential, outpatient, and community-based staff can reinforce psychoeducation, regulation practice, and real-time application when training, supervision, role clarity, and scope-of-practice protections are in place. Peer and direct-care staff should not independently deliver diagnostic assessment or specialized trauma processing unless qualified to do so.

Equipping a broader range of providers to reinforce shared language and skills may increase continuity and frequency of therapeutic practice. This is a scalability proposition of the model and should be evaluated for fidelity, safety, staff burden, and clinical outcomes.

The model also asks providers to develop self-awareness and regulation skills. Provider dysregulation can affect communication, alliance, and the treatment environment, while reflective practice may improve responsiveness. Embodiment of FF-AR principles is therefore treated as a clinical competency rather than proof of a specific neurobiological transmission mechanism.

In this way, FF-AR expands who can reinforce care and where practice occurs, while maintaining the need for clinical governance. The model proposes that healing can be supported across roles, settings, and daily interactions when intervention complexity is matched to provider competence.

A small applied literature on the Accelerated Recovery Program, Certified Compassion Fatigue Specialist Training, and related adaptations has reported reductions in secondary traumatic stress, burnout, or compassion-fatigue indicators among helping professionals and nurses (Gentry et al., 2004; Rajeswari et al., 2020; Robinson et al., 2022). These studies vary in design, sample size, setting, and risk of bias and do not by themselves establish the efficacy of FF-AR for co-occurring trauma and addiction. Any claim that the broader Forward-Facing research program includes 15 empirical peer-reviewed articles should be supported by a complete, verifiable bibliography in the final submission.

DISCUSSION

The Forward-Facing® Accelerated Recovery model proposes a clinically coherent framework for co-occurring trauma and addiction by integrating salutogenesis, functional analysis, regulation skills, relational processes, and graduated application. Traditional disorder-specific approaches remain essential, but they may be strengthened by attention to stress, associative learning, interoception, executive functioning, and the functional role of substance use.
Associative-learning theory offers an accessible account of how cues can acquire threat value and activate physiological and behavioral responses in present-day contexts. Acute stress can reduce access to prefrontal functions needed for reflective choice, while stress and addiction circuitry can increase craving and habitual responding (Arnsten, 2009; Goldstein & Volkow, 2011; Sinha, 2008). This helps explain why cognitive relapse-

prevention plans may be difficult to implement during intense activation, although it does not render such plans ineffective.

FF-AR uses reciprocal inhibition as a clinical bridge to contemporary inhibitory-learning principles. Repeated engagement with activating cues while using effective coping can produce new learning that competes with prior threat expectations (Craske et al., 2014). Because extinction learning is context sensitive and does not erase the original association, the model should avoid absolute claims that relaxation and threat cannot coexist or that conditioned responses will be permanently extinguished.

FF-AR also operationalizes the Active Ingredients approach, including relationship, expectancy, regulation, exposure, cognitive restructuring, psychoeducation, and growth (Gentry et al., 2017). Its preferred sequence begins with relational safety and skill development and then expands application. This sequencing may be clinically useful, but current PTSD/SUD evidence indicates that trauma-focused treatment can be integrated without waiting for prolonged abstinence or completion of a rigid stabilization phase (Hien et al., 2024; Roberts et al., 2023; Simpson et al., 2021).

The model extends formulation beyond discrete Criterion A events to a broader spectrum of adverse life experiences, including developmental, relational, systemic, and potential intergenerational influences. This broader lens may increase clinical relevance, especially because many people in SUD treatment show complex or subthreshold trauma-related presentations (Harvey et al., 2026). It should be used without blurring diagnostic criteria or treating all adversity as equivalent to PTSD.

From a systems perspective, FF-AR is designed to be adaptable across levels of care. Its psychoeducational, experiential, and in vivo components fit residential and community settings, and its salutogenic orientation may reduce stigmatizing language. These implementation and engagement benefits remain propositions to be tested rather than established effects.

Direct empirical research is needed to evaluate FF-AR across populations and settings. Studies should examine posttraumatic symptoms, substance use, craving, relapse, emotional regulation, treatment retention, adverse events, functioning, quality of life, and durability of change. Comparative and dismantling designs could clarify whether regulation-first sequencing adds benefit, for whom, and under what conditions relative to other integrated PTSD/SUD approaches.

CONCLUSION

Forward-Facing® Accelerated Recovery offers a testable framework for TraumAddiction treatment by integrating neurobiological, psychological, relational, and salutogenic principles. It reframes addictive behavior as potentially adaptive in function while retaining attention to its harms and consequences, and it positions regulation as an important component of integrated care rather than a replacement for evidence-based SUD or trauma treatment.

During intense physiological threat, individuals may have reduced access to higher-order cognitive processes involved in decision-making, impulse control, and relapse prevention (Arnsten, 2009). Sustainable recovery may therefore benefit from building regulation capacity before and alongside trauma-focused work. Current evidence supports individualized, concurrent PTSD/SUD treatment rather than a universal requirement for prolonged stabilization or abstinence before trauma processing (Hien et al., 2024; Roberts et al., 2023; Simpson et al., 2021).

Antonovsky's SOC provides a structure through which individuals can build understanding (comprehensibility), identify and use resources (manageability), and reconnect with purpose (meaningfulness). SOC is associated with perceived health and quality of life, although causal claims should remain cautious (Antonovsky, 1987; Eriksson & Lindström, 2006).

By incorporating proposed active ingredients within a capacity-sensitive framework, FF-AR is intended to support safe, collaborative, and clinically responsive intervention. Relationship, hope, psychoeducation, regulation practice, cognitive change, and exposure-based learning each have broader empirical foundations, while their specific configuration within FF-AR requires direct evaluation (Craske et al., 2014; Flückiger et al., 2018; Gentry et al., 2017).

FF-AR further proposes that trained and supervised providers across roles can reinforce regulation and relational safety throughout the treatment milieu. Applied studies of related professional-resilience and Accelerated Recovery interventions provide preliminary support for reductions in secondary traumatic stress and compassion-fatigue outcomes, but they should not be generalized as proof of FF-AR efficacy for TraumAddiction (Gentry et al., 2004; Rajeswari et al., 2020; Robinson et al., 2022).

Ultimately, FF-AR shifts emphasis toward forward-oriented capacity building and intentional living while preserving the need for diagnostic clarity, evidence-based concurrent treatment, informed consent, and outcome monitoring. In doing so, it offers a practical and dignifying clinical hypothesis: that recovery can be strengthened when individuals understand their adaptations, build usable resources, encounter challenges with increasing flexibility, and reconnect with a meaningful life direction.

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FROM SURVIVOR TO THRIVER IN AN AGE OF COMPOUNDING CRISES: FIVE CONVERGING TRENDS, THE CROSSCUTTING ROLE OF STIGMA, AND POSITIVE PATHWAYS FOR TRAUMATIC STRESS AND CRISIS MANAGEMENT

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ABSTRACT

Traumatic stress and crisis management practice is being reshaped by forces that were peripheral a decade ago. This structured narrative review identifies five converging trends, appraises the evidence behind each, and pairs each with positive, evidence-informed pathways forward: (a) compounding crises and cumulative exposure; (b) the re-engineering of early intervention toward psychological first aid, monitoring, and scalable stepped care; (c) treatment innovation, including brief and massed trauma-focused therapies, ICD-11 complex posttraumatic stress disorder, and the contested regulatory course of MDMA-assisted therapy; (d) the digital transformation of crisis care; and (e) moral injury and the wellbeing of helpers. Examination of these trends identified stigma as a cross-cutting determinant of how individuals experience trauma rather than a separate domain. Stigma deters help-seeking, shapes whether and how survivors disclose, and, through negative social reactions, acts as a secondary stressor associated with greater psychopathology; its deterrent effect falls disproportionately on groups heavily exposed to crisis, including military personnel, first responders, and health professionals. The review also finds grounds for optimism: public stigma toward depression has measurably declined in the United States, social contact with people with lived experience is the best-supported stigma-reduction strategy, peer-led programs reduce stigma stress, and training informal supporters to respond well to disclosure shows early benefit. Every reference was cross-checked against at least two independent bibliographic records, and time-sensitive claims were traced to their originating source before being retained. Seven practice propositions are offered to inform interdisciplinary standards consistent with the Academy's aspiration that victims become survivors and survivors become thrivers.

Keywords: traumatic stress, stigma, crisis intervention, psychological first aid, digital mental health, moral injury, posttraumatic growth

INTRODUCTION

Exposure to potentially traumatic events is the statistical norm rather than the exception. In the World Health Organization (WHO) World Mental Health Surveys, which pooled data from 24 countries, roughly seven in ten respondents reported at least one lifetime traumatic event (Kessler et al., 2017), and cross-national lifetime prevalence of posttraumatic stress disorder (PTSD) was estimated at 3.9% in the general population and 5.6% among the trauma-exposed (Koenen et al., 2017). These figures, however, describe a baseline that is shifting. Populations affected by armed conflict carry an estimated one-in-five prevalence of mental disorders (Charlson et al., 2019), and the COVID-19 pandemic placed unprecedented and prolonged strain on health and emergency workforces (Lai et al., 2020; Williamson et al., 2020).

At the same time, the tools available to practitioners have changed. Brief trauma-focused therapies now rival longer protocols (Sloan et al., 2023); a national three-digit crisis line has become a primary point of entry to crisis care in the United States (Saunders, 2026); and generative AI systems are being used for emotional support at scale, with both promising trial data and documented safety gaps (Heinz et al., 2025; McBain et al., 2025). The field therefore faces a dual challenge: absorbing new evidence and technologies while holding to standards that protect survivors from well-intended but ineffective or harmful practices.

Running through all these developments is a factor that shapes how individuals experience trauma yet are often treated as peripheral: stigma. Across 144 studies, stigma was associated with reduced help-seeking for

mental health problems and ranked among the leading barriers to care, with disclosure concerns the most frequently reported stigma-related barrier (Clement et al., 2015). Survivors of sexual and intimate partner violence contend with self-blame, shame, and anticipated or experienced stigmatization (Kennedy & Prock, 2018), and those who most need care is often the most concerned about being stigmatized for seeking it (Hoge et al., 2004). Stigma therefore sits between exposure and recovery, influencing whether a traumatic experience becomes a path toward help or a private burden.

The mission of the American Academy of Experts in Traumatic Stress provides a useful organizing lens for this challenge. The Academy seeks to increase awareness of the effects of traumatic events on human functioning, to help professionals look beyond physical and safety needs to emergent psychological needs, to improve the quality of intervention by establishing meaningful standards across disciplines, to provide training and education, and ultimately to assist victims in becoming survivors and then thrivers. The purpose of this article is threefold: to identify the most consequential current trends in traumatic stress and crisis management and appraise the evidence behind each; to examine stigma as a cross-cutting influence on individual trauma experience within each trend; and to identify positive, evidence-informed pathways forward that can inform interdisciplinary practice standards consistent with that mission.

METHOD

DESIGN

This is a structured narrative review rather than a systematic review or meta-analysis. The narrative design was chosen because the aim was integrative: to identify cross-cutting trends spanning clinical research, health-services policy, regulation, and technology, domains that do not share a common outcome metric suitable for quantitative pooling.

TREND IDENTIFICATION

Candidate trends were retained if they met three criteria: (a) sustained scholarly or policy activity between 2019 and 2026; (b) direct relevance to the assessment, prevention, or treatment of traumatic stress or to the management of crises; and (c) actionable implications for professional practice standards. Five trends met all three criteria. Related topics that were considered but folded into these five, or deferred for reasons of scope, are noted in the Limitations section.

EXAMINATION OF INDIVIDUAL EXPERIENCE

Each candidate trend was also examined against a fourth question: how does the trend alter the lived experience of the individual survivor or helper? All five trends were retained. This examination showed, however, that stigma does not fit as a sixth parallel trend, because it operates within each of the five: it influences whether exposure leads to help-seeking, whether early intervention is accepted, whether treatment is completed, whether digital services are chosen, and whether helpers seek care for themselves. Stigma is therefore treated here as a cross-cutting lens and is examined within every trend. In addition, each trend is paired with a subsection on positive pathways forward, reflecting a strengths-based orientation consistent with the Academy's survivor-to-thriver mission. Where these subsections draw inferences that go beyond the cited evidence, they are identified as the author's interpretation.

SOURCE SELECTION AND CITATION VERIFICATION

Sources were prioritized according to evidentiary weight: systematic reviews and meta-analyses, randomized controlled trials, consensus treatment guidelines, and reports from governmental and intergovernmental bodies. To guard against citation error, each reference was cross-checked against at least two independent records, such as a publisher or DOI landing page together with a bibliographic index (e.g., PubMed), an institutional repository, or a library catalog. Records maintained by the same author or publisher were not counted as independent. Author

lists, titles, volume, issue, page, and DOI information were confirmed against these records.

TIME-SENSITIVE CLAIMS

Several developments discussed here, including the regulatory status of MDMA-assisted therapy, utilization data for the 988 Lifeline, and state legislation on artificial intelligence (AI) in therapy, are too recent to appear in the peer-reviewed literature. For these claims a stricter protocol was applied. First, each claim was classified as either an organization reporting its own data (e.g., a federal oversight report), for which the issuing body is the primary source, or a claim about a third party, which requires independent confirmation. Second, the provenance of each news or organizational source was traced; syndicated wire copies, rewritten press releases, and outlets relying on the same original report were treated as a sole source rather than as independent corroboration. Third, a primary record (e.g., a regulatory document, a legislative or agency release, or a journal notice) was substituted wherever one existed. Claims that could be traced to only a single originating reports were retained only when they were not essential to the argument, and then only with explicit attribution and qualification. All time-sensitive claims are current until September 2026.

STIGMA AS A CROSS-CUTTING LENS

DEFINING STIGMA

Link and Phelan (2001) defined stigma as the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context where power is exercised. Corrigan (2004) distinguished public stigma, the prejudice held by the general population, from self-stigma, the internalization of that prejudice, and described how both interfere with the pursuit of care. For trauma survivors, stigma operates at several levels at once: public attitudes toward mental health conditions; internalized shame and self-blame; anticipated stigma that shapes decisions about disclosure; occupational and institutional stigma that links help-seeking to professional consequences; and event-specific stigma, such as victim-blaming following sexual violence.

HOW STIGMA SHAPES THE INDIVIDUAL EXPERIENCE OF TRAUMA

Help-seeking. A systematic review of 144 studies with 90,189 participants found a small-to-moderate negative association between stigma and help-seeking (median $d = -0.27$), with internalized stigma and stigma attached to treatment most often associated with reduced help-seeking. Stigma was the fourth highest-ranked barrier to care, and concern about disclosure was the most reported stigma barrier. Notably, ethnic minorities, youth, men, and people in the military and health professions were disproportionately deterred (Clement et al., 2015). Several of these groups are among those most heavily exposed to trauma in crisis work.

The paradox of need. In a study of U.S. Army and Marine Corps personnel returning from Iraq and Afghanistan, only 23% to 40% of those whose screening indicated a mental disorder had sought mental health care, and those who screened positive were twice as likely as those who screened negative to report concern about stigmatization (Hoge et al., 2004). A meta-analysis of first responders found that about one third endorsed stigma items, with fears about confidentiality and negative career impact the most frequently endorsed (Haugen et al., 2017). The consequence is that stigma is concentrated among those whose need is greatest, delaying presentation and potentially increasing the risk of chronic post-trauma difficulties.

Disclosure and social reactions. A review of research on female survivors of child sexual abuse, sexual assault, and intimate partner violence documented the pervasive role of stigma and stigmatization, including shame and self-blame, in shaping survivors' identities, disclosure, and help-seeking (Kennedy & Prock, 2018). The responses survivors receive when they do disclose matter: a meta-analysis found that negative social reactions to disclosure of interpersonal violence were robustly associated with greater psychopathology, whereas positive reactions showed weaker protective associations (Dworkin et al., 2019). This finding reframes stigma. It is not only a barrier between survivors and care; stigmatizing responses can function as a secondary stressor.

Convergence with trauma-related shame. Shame and guilt are central to moral injury (Litz et al., 2009), and a persistently negative self-concept is one of the defining features of complex PTSD (Maercker et al., 2013). In the author's interpretation, self-stigma is therefore likely to compound, rather than merely accompany, some of the very symptoms clinicians seek to treat, which strengthens the case for addressing stigma explicitly within trauma care rather than treating it as a matter of public attitudes alone.

FIVE CONVERGING TRENDS

TREND 1: COMPOUNDING CRISES AND CUMULATIVE EXPOSURE

The mental-health consequences of disasters are well documented. A landmark review of 160 samples comprising some 60,000 disaster victims found that psychological impairment was more severe after mass violence than after natural or technological disasters and more severe in developing than in developed countries (Norris et al., 2002). Subsequent reviews estimated PTSD prevalence of roughly 30% to 40% among direct victims, 10% to 20% among rescue workers, and 5% to 10% in the general population following disasters, with wide variation by event and method (Neria et al., 2008), and have emphasized that depression, substance use, and functional impairment frequently accompany or exceed PTSD (Goldmann & Galea, 2014).

What matters for practice is not only the single event but the accumulation of events. Individuals and communities may face successive crises, such as a pandemic followed by an episode of mass violence or a disaster before they have recovered from earlier ones. In these circumstances, pre-event distress, depleted resources, and prior loss become the backdrop against which new trauma unfolds.

Finally, exposure is no longer confined to those physically present. After the 2013 Boston Marathon bombings, individuals who reported six or more hours of daily media exposure to coverage in the following week reported higher acute stress than some individuals who were directly exposed (Holman et al., 2014). In an environment of continuous, algorithmically amplified coverage of successive crises, indirect exposure becomes a plausible contributor to cumulative load. Taken together, these findings argue for assessment practices that capture cumulative and indirect exposure, and for investment in the networked adaptive capacities (economic resources, social capital, information and communication, and community competence) that Norris et al. (2008) identified as the foundations of community resilience.

STIGMA LENS

Framing matters in collective crises. Treating understandable, proportionate distress after a shared crisis as a disorder risk attaching a label that invites self-stigma, whereas dismissing it may leave people who are genuinely impaired without support. Collective events also carry an opportunity: when distress is widely shared and publicly acknowledged, the separation of a labeled individual from others that Link and Phelan (2001) identified as a component of stigma is weakened. In the author's interpretation, community-wide messaging after disasters that normalizes common reactions while clearly signposting help is one of the lower-cost stigma-reduction tools available to crisis managers.

POSITIVE PATHWAYS FORWARD

Several findings point toward constructive responses. Collective efficacy and hope are among the five principles of mass-trauma intervention (Hobfoll et al., 2007), and, in the author's interpretation, shared distress can be channeled into agency when communities are given meaningful roles in their own recovery. The capacities that underpin community resilience, including social capital, information and communication, and community competence, are modifiable and can be strengthened before disasters occur (Norris et al., 2008). Embedding mental health and psychosocial support into disaster preparedness planning, rather than activating it only after an event (IASC, 2007), allows communities facing repeated crises to build on prior recovery rather than start from zero each time.

TREND 2: EARLY INTERVENTION RE-ENGINEERED: FROM DEBRIEFING TO STEPPED, SCALABLE CARE

Few areas of crisis practice have been reshaped by evidence as decisively as early intervention. A Cochrane review found no evidence that single-session individual psychological debriefing prevented PTSD, with some indication that it may increase risk in certain recipients (Rose et al., 2002). A later systematic review and meta-analysis of 61 randomized trials of multiple-session early interventions found no clinically important benefit over usual care when interventions were delivered to all trauma-exposed individuals without screening; by contrast, for individuals already reporting traumatic stress symptoms, trauma-focused cognitive-behavioral therapy and several related approaches showed clinically important benefits (Roberts et al., 2019). The implication is that routine, universal intervention in the immediate aftermath is not supported, whereas targeted intervention for those who remain symptomatic is.

In place of debriefing, the field has converged on psychological first aid (PFA) and related approaches built around five empirically informed principles: promoting a sense of safety, calming, self- and collective efficacy, connectedness, and hope (Hobfoll et al., 2007). These principles are operationalized in widely used guides for responders in high-income settings (Brymer et al., 2006) and for field workers in humanitarian contexts (World Health Organization et al., 2011), and the layered model of mental health and psychosocial support set out by the Inter-Agency Standing Committee (IASC, 2007) situates PFA within a broader pyramid extending from basic services and security to specialized care. It should be acknowledged that PFA is evidence-informed rather than directly established through randomized trials; its principles derive from research on risk and resilience, which is itself an argument for continued outcome evaluation.

The most consequential development in this area is the emergence of brief, manualized interventions that trained non-specialists can deliver under supervision. The WHO's five-session Problem Management Plus (PM+) reduced psychological distress and PTSD symptoms relative to enhanced usual care among conflict-affected adults in Pakistan (Rahman et al., 2016) and among women with histories of gender-based violence in Nairobi, Kenya, where it was delivered by lay community health workers after eight days of training (Bryant et al., 2017). The group-based Self-Help Plus program, consisting of five audio-guided workshops for groups of 20 to 30 participants led by briefly trained facilitators, reduced psychological distress at three months among South Sudanese refugee women in Uganda (Tol et al., 2020). These trials suggest a realistic path to scale in settings where specialists are scarce, which increasingly includes disaster-affected regions of high-income countries.

The resulting model of early intervention is stepped: universal PFA and practical support; active monitoring and screening in the weeks after the event; low-intensity, scalable interventions for those with persistent distress; and specialist trauma-focused treatment for those who meet diagnostic thresholds or do not respond. This sequence is well aligned with the Academy's charge to look beyond physical and safety needs without medicalizing normal distress.

STIGMA LENS

The shift away from universal debriefing has a stigma dimension that is rarely discussed. Psychological first aid is explicitly non-pathologizing: it treats most early reactions as understandable responses to extraordinary events and avoids premature diagnostic labeling. Screening, by contrast, carries a risk that being identified as symptomatic is experienced as being marked out, so screening processes should be framed as routine and universal rather than selective. Location also matters. In the Kenyan PM+ trial, the intervention was delivered in the community by lay community health workers rather than in health facilities (Bryant et al., 2017). Given that stigma attached to treatment is among the forms most strongly associated with reduced help-seeking (Clement et al., 2015), community-based delivery by trusted local helpers is, in the author's interpretation, a plausible mechanism for lowering the stigma threshold, and one that deserves direct evaluation.

POSITIVE PATHWAYS FORWARD

Because negative social reactions to disclosure are associated with worse outcomes (Dworkin et al., 2019), a promising frontier is extending early intervention beyond professionals to the family members, friends,

and coworkers to whom survivors first disclose. In a randomized evaluation of a program designed to improve how college students respond to disclosures of sexual and partner violence, participants who subsequently experienced victimization themselves showed benefits in posttraumatic stress (Edwards et al., 2021). Combined with the growing evidence for task-sharing (Bryant et al., 2017; Rahman et al., 2016; Tol et al., 2020), this suggests a future in which communities, not only specialists, are equipped to offer the first layer of trauma-informed support.

TREATMENT INNOVATION: BRIEF, INTENSIVE, AND PHARMACOLOGICALLY ASSISTED CARE

The International Society for Traumatic Stress Studies (ISTSS) guidelines issued strong recommendations for several trauma-focused psychological treatments for adults, including cognitive processing therapy, cognitive therapy, eye movement desensitization and reprocessing, individual cognitive-behavioral therapy with a trauma focus, and prolonged exposure (Bisson et al., 2019). The contemporary frontier is less about identifying new efficacious treatments than about making effective treatment shorter, more tolerable, and more completable.

BRIEF AND MASSED FORMATS

Written exposure therapy (WET), a five-session protocol with no between-session assignments, was found noninferior to prolonged exposure (PE) among 178 veterans at three Veterans Affairs medical centers, with fewer participants dropping out of WET (Sloan et al., 2023). Separately, a randomized trial with active-duty military personnel found that PE delivered in a massed format over two weeks was noninferior to the same treatment delivered over eight weeks (Foa et al., 2018). Brief and intensive formats matter for crisis populations because responders, displaced persons, and survivors of recurrent disasters often cannot commit to three months of weekly sessions.

COMPLEX PTSD

The eleventh revision of the *International Classification of Diseases* (ICD-11) introduced complex PTSD, which comprises the core PTSD symptoms plus disturbances in self-organization: affect dysregulation, negative self-concept, and interpersonal difficulties (Maercker et al., 2013). The International Trauma Questionnaire provides a brief self-report instrument for distinguishing PTSD from complex PTSD (Cloitre et al., 2018). The diagnosis is especially relevant to survivors of prolonged or repeated trauma, such as captivity, childhood abuse, trafficking, and protracted conflict, and it has implications for treatment sequencing and for the pacing of trauma-focused work.

MDMA-ASSISTED THERAPY: A CASE STUDY IN EVIDENTIARY STANDARDS

Two phase 3 trials reported that MDMA-assisted therapy produced significantly greater reductions in PTSD symptom severity than placebo with therapy (Mitchell et al., 2021, 2023). Nonetheless, in June 2024 a U.S. Food and Drug Administration (FDA) advisory committee voted 2 to 9 against the effectiveness of the treatment and 1 to 10 against the conclusion that its benefits outweighed its risks, and on August 9, 2024, the FDA declined approval, requesting an additional phase 3 trial (American Journal of Managed Care, 2024). The concerns raised publicly included functional unblinding, durability of benefit, and the adequacy of adverse-event capture. In the same month, the journal *Psychopharmacology* retracted three papers reporting earlier-phase data, citing protocol violations amounting to unethical conduct at one study site and incomplete disclosure of competing interests (Jerome et al., 2024; Keshavan, 2024; Mithoefer et al., 2024). The FDA made its complete response letter public in September 2025 (Multidisciplinary Association for Psychedelic Studies [MAPS], 2025), and in July 2026 it finalized guidance on the design of clinical investigations of psychedelic drugs (U.S. Food and Drug Administration [FDA], 2026). In August 2026 the sponsor, since renamed Resilient Pharmaceuticals, was reported to have resubmitted its application without a new phase 3 trial (Psychedelic Alpha, 2026). That report relied on unnamed sources; as of September 2026, the resubmission had not been publicly confirmed by the sponsor or the FDA, and a MAPS (2026) statement responding to it did not independently confirm it.

Whatever the eventual regulatory outcome, this episode is instructive for standard-setting. It illustrates

that statistically significant trial results are necessary but not sufficient, that the integrity of the therapeutic frame itself is a safety issue when patients are in altered states, and that practitioners will field questions from survivors about treatments that are not yet approved. A standards-based response is to provide balanced, accurate information about the status of emerging treatments, to avoid both dismissiveness and promotion, and to continue offering the established treatments endorsed by current guidelines.

STIGMA LENS

Treatment format interacts with stigma. Brief protocols reduce the number of clinic visits and the duration of a person's identity as someone in therapy, and written exposure therapy requires no between-session assignments (Sloan et al., 2023). Diagnostic labels are double-edged. Recognition of complex PTSD can validate the experience of survivors of prolonged trauma and guide treatment, yet any label can be internalized. Collaborative, strengths-based case formulation that frames diagnosis as a description of understandable adaptations rather than a statement about character is consistent with trauma-informed principles (SAMHSA, 2014).

POSITIVE PATHWAYS FORWARD

The direction of travel is encouraging. Treatments are becoming shorter and more completable without loss of effectiveness (Foa et al., 2018; Sloan et al., 2023), which means that more survivors can reach the end of an effective course of care. The regulatory record for MDMA-assisted therapy, whatever its outcome, has produced clearer standards for how novel trauma treatments should be evaluated, including finalized FDA guidance on trial design, safety characterization, and long-term follow-up (FDA, 2026). An expanding menu of evidence-based options allows care to be matched to survivors' preferences and constraints, which is itself a form of respect for their autonomy.

TREND 4: THE DIGITAL TRANSFORMATION OF CRISIS CARE

TELEHEALTH

The evidence that trauma-focused therapy can be delivered remotely without loss of efficacy predates the pandemic. In a randomized trial with 132 veterans, PE delivered by home-based video telehealth was noninferior to in-person PE for PTSD outcomes at post-treatment and at three- and six-month follow-up (Acierno et al., 2017). Home-based delivery reduces travel time, cost, lost work, and stigma, which are barriers that loom especially large for rural populations and for survivors displaced by disaster.

THE 988 SUICIDE AND CRISIS LIFELINE

On July 16, 2022, the United States transitioned its national suicide prevention line to the three-digit number 988, connecting callers, texters, and chat users to a network of more than two hundred local and state-funded crisis centers. By March 2026 Lifeline had received approximately 23.3 million contacts, and volume was about 15% higher than a year earlier (Saunders, 2026). A 2026 federal oversight review examined the Lifeline's capacity and the measures used to assess its performance, including contact volume, answer rates, and time to answer (U.S. Government Accountability Office [GAO], 2026). For crisis professionals, 988 represents both an opportunity and a standards challenge: it creates a common front door to crisis care, but its value depends on the quality and availability of the mobile crisis teams, stabilization services, and follow-up care behind it, much of which is funded at the state and local level (Saunders, 2026).

GENERATIVE ARTIFICIAL INTELLIGENCE

The first randomized trial of a fully generative AI therapy chatbot enrolled 210 adults with clinically significant symptoms of major depressive disorder, generalized anxiety disorder, or high risk for feeding and eating disorders; compared with a waitlist control, participants using the chatbot showed significant symptom reductions and rated their therapeutic alliance with it as comparable to that reported with human therapists (Heinz et al., 2025). The trial did not target PTSD, and its

authors cautioned that no generative AI agent is ready to operate autonomously in mental health care, given the range of high-risk scenarios it may encounter.

That caution is borne out by safety evaluations. When 30 suicide-related questions of graded risk were posed to three widely used general-purpose chatbots, responses were generally aligned with expert clinician judgment at the very-low-risk and very-high-risk ends of the spectrum but inconsistent for intermediate-risk questions (McBain et al., 2025). The study was published amid litigation alleging chatbot involvement in an adolescent's suicide (O'Brien, 2025). In August 2025, Illinois enacted the Wellness and Oversight for Psychological Resources Act, which prohibits the use of AI to provide therapy or make therapeutic decisions while permitting its use for administrative and supplementary support (Illinois Department of Financial and Professional Regulation [IDFPR], 2025). Because trauma-exposed individuals carry elevated suicide risk and may turn to chatbots precisely when human services are unavailable, as in the aftermath of a disaster, the gap between general conversational competence and crisis-specific safety is a central concern for this field.

The standards implications are threefold. First, digital tools used in crisis contexts should include reliable, tested pathways to human responders. Second, practitioners need digital competence: the ability to ask clients about their use of chatbots and apps and to advise them on risks. Third, AI tools marketed for emotional support should be evaluated against suicide-safety benchmarks and, specifically, against the needs of trauma-exposed users before being recommended by professionals.

STIGMA LENS

Digital channels may lower some stigma barriers while raising others. Because disclosure concerns are the most frequently reported stigma barrier (Clement et al., 2015), services that allow people to seek help privately, without being seen entering a clinic, address a central mechanism of stigma. The authors of the home-based telehealth trial identified reduced stigma, alongside reduced travel time, cost, and lost work, as a potential advantage of delivering therapy into patients' homes (Acierno et al., 2017). Utilization of 988 by text grew by roughly 260% between July 2022 and September 2025, considerably faster than calls (GAO, 2026), consistent with, though not proof of a preference for lower-exposure channels. At the same time, fears about confidentiality were the most endorsed stigma concern among first responders (Haugen et al., 2017), so digital services will earn trust only if they are transparent about how data are stored, shared, and used.

POSITIVE PATHWAYS FORWARD

The sustained growth in 988 contacts (Saunders, 2026) indicates that large numbers of people are willing to reach out when a simple, low-threshold route is available. The most promising future models are hybrid: digital tools that lower the threshold for first contact, paired with reliable handoffs to train humans for risk assessment and ongoing care. Evaluating AI tools specifically with trauma-exposed users, building clear privacy protection, and designing services with input from people with lived experience would allow the field to capture the stigma-reducing potential of digital care while managing its risks.

TREND 5: MORAL INJURY AND THE WELLBEING OF THOSE WHO HELP

The costs borne by helpers have long been recognized under the rubrics of compassion fatigue and secondary traumatic stress (Figley, 1995). The construct of moral injury extends this understanding. Litz et al. (2009) proposed that lasting psychological harm can arise from perpetrating, failing to prevent, witnessing, or learning about acts that transgress deeply held moral beliefs, and that such harm is characterized more by guilt, shame, and a sense of betrayal than by the fear-based processes central to PTSD.

The COVID-19 pandemic moved moral injury from military psychology into mainstream occupational health. In an early cross-sectional survey of 1,257 health care workers in China, approximately half reported symptoms of depression, and a large majority reported distress, with nurses, women, and frontline workers at higher risk (Lai et al., 2020). Williamson et al. (2020) argued that resource constraints forcing frontline workers into decisions that conflicted with their values

placed them at risk of moral injury, and identified risk factors including unsupportive leadership, lack of preparation for the emotional consequences of decisions, concurrent personal trauma, and limited social support.

This trend matters for crisis management because the same conditions that produce moral injury in health systems (scarcity, triage, and institutional failure) are intrinsic to disaster response. It also shifts responsibility upward: moral injury is shaped by leadership and organizational conduct, not solely by individual coping. Standards for crisis organizations should therefore address preparation for potentially morally injurious events, candid leadership communication, structured peer support, and access to confidential care, rather than relying on individual resilience training alone.

STIGMA LENS

Helpers face a distinctive form of stigma. People in the military and health professions are among the groups most deterred from help-seeking by stigma (Clement et al., 2015), and first responders' most common concerns involve confidentiality and career consequences (Haugen et al., 2017). Occupational cultures that prize stoicism can turn help-seeking into a perceived admission of unfitness for duty. Because moral injury is characterized by guilt and shame (Litz et al., 2009), the helper who has been morally injured may be especially vulnerable to self-stigma, and therefore especially unlikely to come forward.

POSITIVE PATHWAYS FORWARD

Organizations can change these conditions. Recommended measures include preparing staff in advance for potentially morally injurious events, ensuring leaders acknowledge problematic decisions and take responsibility for them, and strengthening social support (Williamson et al., 2020). Creating confidential routes to care that are clearly separated from fitness-for-duty and promotion decisions addresses the specific fears that first responders report (Haugen et al., 2017). Peer-led approaches are also promising adaptations of the Honest, Open, Proud program for veterans and active-duty soldiers have been developed and await evaluation (Rüsch & Kösters, 2021). When respected leaders and colleagues speak openly about seeking help, they model the social contact that is the best-supported mechanism for reducing stigma (Thornicroft et al., 2022).

DISCUSSION

INTEGRATING THE TRENDS: THE SURVIVOR-TO-THRIVER CONTINUUM

Although the five trends arise from different literatures, they converge on a common point: effective trauma and crisis practice are increasingly defined by what happens across time and systems rather than by any single intervention. The Academy's survivor-to-thriver aspiration provides a unifying frame, and it is supported by two bodies of research that should be held in tension.

The first is resilience research, which has established that a stable trajectory of healthy functioning is the most common response to potentially traumatic events and that resilience is not a rare or exceptional trait (Bonanno, 2004). This finding underpins the watchful-waiting and stepped-care logic described under Trend 2: most survivors do not need formal treatment, and intervention that assumes otherwise may interfere with natural recovery.

The second is research on posttraumatic growth, the positive change that some survivors report in their relationships, sense of personal strength, appreciation of life, spirituality, and perception of new possibilities

Table 1

Five Converging Trends, Supporting Evidence, and Implications for Practice Standards

Trend	Core evidence	Implication for practice standards	Academy mission pillar
1. Compounding crises	Disaster sequelae reviews; media-exposure research; community resilience model	Assess cumulative and indirect (media) exposure; distinguish adaptive distress from disorder; invest in community resilience capacities	Increase awareness; look beyond physical needs
2. Re-engineered early intervention	Debriefing and early-intervention reviews; Hobfoll et al. principles; PM+ and Self-Help Plus trials	Replace routine single-session debriefing with PFA, monitoring, screening, and stepped care; supervised task-sharing	Establish standards; look beyond physical needs
3. Treatment innovation	ISTSS guidelines; WET and massed PE trials; ICD-11 CPTSD; MDMA-AT trials and regulatory record	Offer brief and intensive trauma-focused options; assess CPTSD; balanced informed consent about emerging therapies	Establish standards; training and education
4. Digital transformation	Home-based telehealth PE trial; 988 volume data; generative-AI chatbot RCT and safety evaluations	Human-in-the-loop escalation; digital competence; evaluate AI tools against suicide-safety benchmarks	Establish standards; training and education
5. Moral injury and helper wellbeing	Moral injury model; COVID-19 health-worker data; secondary traumatic stress literature	Organizational duty of care; preparation for morally injurious events; peer and leadership support	Establish standards; survivor to thriver

Note. PFA = psychological first aid; PM+ = Problem Management Plus; ISTSS = International Society for Traumatic Stress Studies; WET = written exposure therapy; PE = prolonged exposure; CPTSD = complex posttraumatic stress disorder; MDMA-AT = MDMA-assisted therapy; RCT = randomized controlled trial.

Table 2

How Stigma Operates Within Each Trend and Positive Pathways Forward

Trend	How stigma operates	Positive pathways forward
1. Compounding crises	Risk of pathologizing proportionate distress; shared events can weaken the separation component of stigma	Normalizing community messaging with clear signposting; channel concern into collective efficacy; build resilience capacities before events
2.Early intervention	Selective screening can feel like being marked out; stigma attached to treatment deters uptake	Universal, routine screening; community-based delivery by trusted lay helpers; train family, friends, and coworkers to respond well to disclosure
3. Treatment innovation	Diagnostic labels can be internalized; lengthy treatment prolongs identity as a patient	Brief, completable formats; collaborative, strengths-based formulation; clearer standards for evaluating novel therapies
4. Digital transformation	Lowers exposure-based disclosure barriers but raises confidentiality concerns	Private, low-threshold first contact with reliable human handoffs; transparent data practices; design with people with lived experience
5. Helper wellbeing	Occupational stigma and fear of career consequences; shame-based self-stigma after moral injury	Confidential care separated from fitness-for-duty decisions; leaders who acknowledge challenging decisions; peer-led programs and visible help-seeking by leaders

Note. Pathways combine cited evidence with the author's interpretation; see text for the distinction in each case.

(Tedeschi & Calhoun, 1996, 2004). Growth is the construct closest to the idea of the thriver. However, literature also counsels caution. When self-reported growth was compared with prospectively measured change, the two were only weakly related, suggesting that retrospective reports of growth may partly reflect coping or meaning-making rather than measured change (Frazier et al., 2009), and reviewers have called for more rigorous, longitudinal designs (Jayawickreme & Blackie, 2014). For practice, the lesson is to create conditions in which growth can occur (safety, connectedness, agency, and meaning) without prescribing growth as an expected outcome or implying that survivors who do not report it have failed. This stance aligns with the principles of a trauma-informed approach: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and attention to cultural, historical, and gender issues (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

REDUCING STIGMA: EVIDENCE-BASED PATHWAYS TOWARD THRIVING

The stigma evidence reviewed above could be read as discouraging, but the broader literature supports a more hopeful conclusion: stigma is modifiable. Using nationally representative U.S. data collected in 1996, 2006, and 2018, Pescosolido et al. (2021) reported the first evidence of a significant decline in public stigma toward depression, including reduced desire for social distance in the later period, although stigma toward schizophrenia and alcohol dependence did not show comparable improvement. Change is possible, but it is uneven and requires sustained effort.

The Lancet Commission on ending stigma and discrimination in mental health, produced by more than 50 contributors including people with lived experience, concluded that social contact between people with and without lived experience is the most effective way to reduce stigma, and that people with lived experience are the key agents of change (Thornicroft et al., 2022). At the individual level, the peer-led Honest, Open, Proud program supports people in making their own decisions about disclosure; a meta-analysis of five randomized trials found a moderate reduction in stigma stress at the end of the program and a small but significant reduction in self-stigma at short-term follow-up, while noting that long-term effects are not yet known (Rüsch & Kösters, 2021). At the interpersonal level, programs that train potential disclosure recipients show early promise (Edwards et al., 2021).

These findings connect directly to the Academy's survivor-to-thriver aspiration. If people with lived experience are the most effective agents of stigma reduction, then one meaningful expression of thriving is the survivor who, by choice and with support, helps others by sharing their experience. Such roles must be voluntary, adequately supported, and free of tokenism, and no survivor should be expected to disclose to be regarded as having recovered. Where they are chosen freely, however, they turn the individual process of recovery into a collective resource.

PROPOSITIONS FOR INTERDISCIPLINARY PRACTICE STANDARDS

Drawing on the evidence reviewed, seven propositions are offered for consideration by the Academy and allied professional bodies as a basis for interdisciplinary standards.

1. **Assess cumulative and indirect exposure.** Intake and screening in crisis contexts should capture prior disasters, ongoing adversity, and heavy media exposure, not only the index event (Holman et al., 2014; Norris et al., 2002).
2. **Retire routine single-session debriefing in favor of stepped care.** Universal prompt response should consist of PFA and practical support, followed by monitoring, screening, and targeted trauma-focused intervention for those who remain symptomatic (Roberts et al., 2019; Rose et al., 2002).
3. **Build supervised task-sharing capacity.** Organizations should train and supervise non-specialists to deliver evidence-based low-intensity interventions such as PM+ and Self-Help Plus, particularly where specialist capacity is limited (Bryant et al., 2017; Tol et al., 2020).
4. **Offer brief and intensive trauma-focused options and assessment for complex PTSD.** Treatment menus should include brief (e.g., WET) and massed

formats to improve completion, and assessment should distinguish PTSD from complex PTSD (Cloitre et al., 2018; Foa et al., 2018; Sloan et al., 2023).

5. **Adopt human-in-the-loop standards for digital crisis tools.** Any digital or AI tool used or recommended in crisis contexts should include tested escalation pathways to human responders and be evaluated against suicide-safety benchmarks (Heinz et al., 2025; McBain et al., 2025).
6. **Treat helper wellbeing as an organizational duty.** Crisis organizations should prepare staff for potentially morally injurious events, ensure supportive leadership communication and peer support, and provide confidential access to care (Litz et al., 2009; Williamson et al., 2020).
7. **Embed stigma reduction at every level of crisis response.** Use non-pathologizing language in early response, frame screening as routine, prepare informal supporters to respond well to disclosure, separate confidential help-seeking from career consequences, and involve people with lived experience in the design and delivery of services (Clement et al., 2015; Dworkin et al., 2019; Haugen et al., 2017; Thornicroft et al., 2022).

RESEARCH AGENDA

Several gaps limit the translation of these trends into firm standards. Prospective cohort studies are needed to model cumulative exposure across successive disasters and other crises and to distinguish proportionate distress from clinically significant impairment. Randomized evaluation of PFA itself, as distinct from the principles that inform it, remains scarce. Generative AI tools require evaluation specifically in trauma-exposed and acutely suicidal populations, using multi-turn rather than single-question safety tests. Controlled trials of interventions targeting moral injury in civilian responder populations are needed. Finally, most of the evidence reviewed here derives from high-income countries; scalable interventions have been tested in low-resource settings, but their implementation in disaster-affected communities within high-income countries, and the equity of digital crisis services across language, disability, and connectivity divides, warrant dedicated study. Stigma, too, requires dedicated attention: trauma intervention trials rarely measure stigma, self-stigma, or disclosure outcomes, and doing so routinely would clarify whether interventions reduce these burdens. Adaptations of peer-led programs such as Honest, Open, Proud for trauma survivors, veterans, and first responders should be evaluated in controlled trials, and research is needed on whether private digital channels increase help-seeking among the groups most deterred by stigma.

LIMITATIONS

This review has several limitations. As a narrative rather than a systematic review, it is susceptible to selection bias, and the identification of five trends reflects judgment that other authors might exercise differently. Topics that were considered but were not given separate treatment include mass-violence preparedness in schools and workplaces, the mental-health sequelae of armed conflict for diaspora communities, and pharmacological and neuromodulatory adjuncts other than MDMA. Policy examples are drawn largely from the United States. Much of the stigma evidence derives from research on mental health conditions generally rather than on trauma specifically, and several links between stigma and the five trends are offered as interpretation, identified as such in the text, rather than as established findings. Finally, several developments, particularly the regulatory status of MDMA-assisted therapy and utilization data for the 988 Lifeline, are evolving rapidly; the account given here is current to September 2026. In particular, the reported resubmission of MDMA-assisted therapy for FDA review rests on a single unconfirmed report and should be treated as provisional.

CONCLUSION

The landscape of traumatic stress and crisis management is being reshaped by compounding crises, a maturing evidence base for early intervention, innovation in treatment format and pharmacology, the digitization of crisis care, and a growing recognition of the moral costs borne by helpers. Each trend brings both opportunity and risk, and within each, stigma shapes whether individuals turn toward help or away from it. The evidence also shows that stigma can be

reduced, most effectively through contact with people who have lived experience, through peer support, and through communities equipped to respond well when survivors disclose. What unites an effective professional response is fidelity to evidence, humility about what remains unknown, and a consistent orientation toward the whole trajectory of recovery. That trajectory begins with safety and basic needs, extends through the psychological needs that emerge after crisis, and, where conditions allow, reaches toward the Academy's aspiration that victims become survivors and survivors become thrivers.

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THE ARCHITECTURE OF INTERNAL ARMOR: TRAUMATIC STRESS, PERFORMANCE DRIFT, AND THE MECHANICS OF PSYCHOLOGICAL SHUTDOWN IN FIRST RESPONDERS

JOSE JOHN CALDERON

I. INTRODUCTION: THE ILLUSION BEHIND THE BADGE

The blue and red lights of the patrol car sliced through the heavy midnight air, casting rhythmic shadows against the concrete walls of the city. Behind the wheel sat an officer whose uniform signified authority, control, and structure. To the outside world, this figure was a shield, a steady presence trained to absorb the chaos of a broken world without fracturing. Yet, as the radio hummed with the quiet static of the late shift, the internal reality told a starkly different story. Beneath the badge lies a complex psychological ecosystem constantly navigating the long, winding road of cumulative traumatic stress.

In field testing trauma interventions, the primary challenge is recognizing that the heaviest armor a first responder carries is rarely the type fabricated from ballistic nylon and steel. Rather, the most resilient, and ultimately destructive, armor is a psychological defense system forged in secret, often tracing its roots to foundational vulnerabilities, and reinforced piece by piece to protect a wounded heart.

For the law enforcement professional, the critical vulnerabilities in this tactical armor do not typically manifest during the dangerous confrontation on city streets. Instead, they disrupt the quietest, most private corners of an officer's life. The cracks reveal themselves in pacing footsteps across a midnight floor, and in the unspoken frustrations that strain the walls of the home, ultimately straining the individual's very existence.

For years, first responders fight these battles in the dark, managing an invisible pressure that threatens to dismantle their psychological and emotional foundations. They learn to wear highly sophisticated masks of denial, rationalize behavioral volatility, and bury acute secondary trauma beneath a lifetime of rigid, institutional discipline.

II. THE ANATOMY OF COMPOSURE AND CUMULATIVE TRAUMA (CASE STUDY)

To understand the systemic pathology of this internal armor, clinical crisis managers must examine the profound disparity between outward professional composure and latent internal suffering. The catastrophic failure of an officer's coping mechanism is rarely telegraphed; it is masked by the very routines designed to project stability.

A seminal turning point in my own decade law enforcement career occurred when a close coworker and friend took his own life. The operational shock within our department was absolute; there were no observable clinical markers or behavioral indicators pointing toward active suicidal ideation.

He was a peer with whom I had shared countless ordinary conversations. We regularly logged our 10-7 breaks together, the standard police dispatch code for taking a meal break. These were routine, uncomplicated periods of decompression: talking, eating, and simply sharing space as colleagues.

Looking back across the landscape of that trauma, the most unsettling variable is the realization that I interacted with him, engaged in normal routines, and operated in close physical proximity, yet had zero visibility into the acute internal crisis he was actively enduring. Following this tragedy, a secondary wave of traumatic stress began to settle into my own consciousness. The event shattered the illusion of institutional invulnerability, prompting an unsettling

existential question: Could the same dark ideation eventually breach my own internal armor?

This realization forced an immediate confrontation with hidden personal vulnerability. In the immediate aftermath, the profound psychological impact is difficult to fully categorize; however, a retrospective analysis reveals that the subconscious was processing an institutional crisis. The distress was not driven by a personal desire for self-harm, but rather by the terrifying diagnostic reality that an individual can suffer severe psychological decay without peer networks ever detecting the collapse.

First responders spend operational lifetimes answering the crises of others, absorbing secondary trauma, and acting as the anchor expected to maintain absolute emotional equilibrium. Yet, this specific loss illuminated a national epidemic within the first responder community. Behind the badge is a human being who can hurt, who can struggle, and who can become completely overwhelmed by the crushing emotional weight of the profession. When institutional expectations demand absolute performance, the person standing right next to you on a high stress call may be carrying an invisible mountain of traumatic stress. The individual perceived to be holding the line is frequently the one struggling simply to hold themselves together.

III. THE MECHANICS OF PERFORMANCE DRIFT AND BEHAVIORAL COPE

To survive the persistent threats inherent in first responder operations, the internal armor must adapt by creating functional coping mechanisms. However, when an individual operates within a highly volatile environment without targeted trauma decompression, these survival mechanisms undergo a pathological mutation known as Performance Drift.

When applied clinically, this drift can be diagnosed through two distinct structural frameworks developed from multi-decade field observation (see figure 1 and table 1).

1. THE GUNSHOT ENVIRONMENT AND TOXIC ACHIEVEMENT ARCHITECTURE

The first phase of psychological drift begins in what is conceptually defined as a **Gunshot Environment.** This is an atmosphere of extreme operational stress, structural volatility, or historical trauma where even minor errors carry catastrophic consequences. To survive, the practitioner develops a hyper-vigilant reflex demanding absolute perfection.

Because the internal landscape feels completely uncontrollable, the individual seeks an external **Escape Route** where variables can be managed. In first responders, this frequently manifests as channeling all survival energy into measurable professional achievements. The officer becomes a master of the technical craft, excelling in investigations, leadership metrics, and institutional benchmarks.

This hyper focus serves as a legitimate, highly praised means to flee a chaotic inner reality. However, because the underlying traumatic stress is avoided rather than processed, the system inevitably reaches a point of **Structural Collapse.** The coping mechanism transforms into an addiction to labor. The professional operates on an unsustainable loop, remaining at the office from 8:00 AM to 10:00 PM, while their physical health, emotional capacity, and family structures face total deterioration.

2. THE PATHOLOGY OF UNHOLY BURDEN-BEARING

As Performance Drift deepens, it alters how the professional handles the acute trauma of the populations they serve. The practitioner subconsciously transitions into a state of **Unholy Burden Bearing,** which stands in stark clinical opposition to healthy, detached crisis management (see table 2).

Exhaustion: Total burnout across physical and psychological domains. **Spiritual Adultery:** Displacement of foundational values for false anchors.

Accurate Discernment: High-level operational

Figure 1.

THE MECHANICS OF PERFORMANCE DRIFT

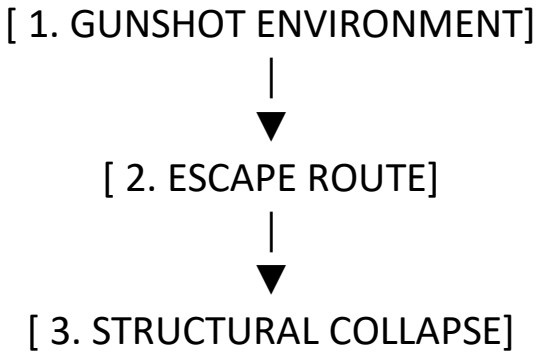


Table 1.

THE MECHANICS OF PERFORMANCE DRIFT

Phase	Operational Manifestation	Core Dynamic
1. Gunshot Environment	Extreme environmental stress demands absolute perfection.	The Survival Trigger: Volatile, high-stakes surroundings force a hyper vigilance loop where mistakes feel fatal.
2. Escape Route	Excelling in academic or occupational labor to flee reality.	The Deflection Mask: Channeling all survival energy into visible, measurable success to escape unresolved internal trauma.
3. Structural Collapse	Extended overwork hours directly forcing family deterioration.	Systemic Exhaustion: The coping shield becomes a functional addiction, destroying personal relationships, health, and stability.

Table 2.

THE PATHOLOGY OF UNHOLY BURDEN-BEARING

Functional Dynamic	Unholy Burden-Bearing	Healthy Crisis Management (Holy Intercession)
Core Operational Action	Attempting to absorb the systemic pain and trauma of the environment within one's own human strength and ego.	Detaching from the load and utilizing an external, transcendent strength to direct the environmental turbulence away from the self.
Systemic Results	Empathetic Defilement: Contamination of the inner world by secondary trauma.	

awareness. **Supernatural Protection:** Inherent immunity to secondary trauma. **True Liberation:** Sustainable professional longevity.

Under the framework of **Unholy Burden Bearing,** the first responder attempts to act as a cosmic sponge, trying to personally internalize and resolve the systemic brokenness they witness on the streets. This survival strategy is structurally flawed. Because human capacity is finite, absorbing environmental chaos leads directly to Empathetic Defilement, where the grit of the city permanently stains the officer's worldview, followed by acute exhaustion and a total breakdown of foundational values.

Conversely, sustainable resilience requires a structured transition toward a detached model. By learning to release the weight of the crisis rather than absorbing it, the practitioner secures accurate operational discernment and supernatural protection, breaking the cycle of cumulative trauma.

IV. SYSTEMIC SYSTEM DISRUPTION: THE ANATOMY OF SHUTDOWN

When the behavioral coping strategies of **Performance Drift** and **Unholy Burden Bearing** are sustained over an extended professional career, the human system inevitably reaches its absolute limit. The internal armor, designed to shield the professional from external trauma, turns inward, suffocating the individual's emotional and psychological capacity. This structural collapse is not sudden, but a predictable, progressive sequence of systemic decay known as *The Anatomy of Shutdown* (see figure 2 and table 3).

1. STAGE 1: PERFORMANCE ORIENTATION (CONTINUOUS STRIVING)

The baseline of this destructive progression is rooted in a chronic **Performance Orientation.** Operating under the illusion of the internal armor, the first responder engages in a relentless, continuous striving to validate their own worth, meaning, and security through operational output. Every successful call, promotion, or administrative accolade is weaponized as a temporary shield against unresolved underlying trauma. Because validation is entirely performance dependent, the practitioner cannot rest. The ego demands higher metrics, longer shifts, and a flawless professional facade, establishing an unsustainable loop of achievement based survival.

2. STAGE 2: THE SPIRIT SHUTS DOWN (ENERGY DEPLETION)

When performance fails to heal the internal wounds, or when cumulative secondary trauma overloads the practitioner's coping capacity, the system experiences a fundamental disruption: **The Spirit Shuts Down.** In this critical stage, the core human drive, the deep internal wellspring of hope, motivation, and vitality, runs completely dry.

The individual discovers that raw willpower and institutional discipline can no longer supply the energy required to sustain the professional mask. Operational tasks that were once routine become monumental burdens. The responder experiences a profound sense of internal numbness and emotional detachment. At this juncture, the illusion of invulnerability is shattered; hope is lost, and the individual realizes they are completely bankrupt of the internal fuel required to face the daily horrors of the field.

3. STAGE 3: DEEP DEPRESSION STAGE (COMPLETE PARALYSIS)

The final stage of this progression is the drop into the **Deep Depression Stage.** This is the clinical manifestation of total systemic failure. When the internal spirit is entirely depleted, the physical and psychological architecture enters a state of complete paralysis and profound hopelessness.

The armor has completely collapsed in on itself, trapping the first responder in a cognitive prison. Outwardly, this presents as severe behavioral withdrawal, operational burnout, and an inability to perform basic functions. Inwardly, it is a state of total cessation, where the individual perceives no viable path forward, no escape from the accumulated trauma, and no hope for restoration. It is within this paralyzing dark space that hidden ideation thrives, as the mind

Figure 2.

THE ANATOMY OF SHUTDOWN

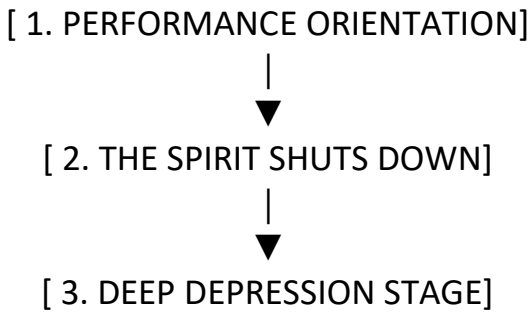


Table 3.

THE ANATOMY OF SHUTDOWN

Phase	Operational Manifestation	Core Dynamic
1. Performance Orientation	Continuous striving to earn worth and validation.	The Facade: Attempting to outrun internal wounds by maintaining a flawless professional output and achievement-based survival.
2. The Spirit Shuts Down	Internal energy is fully depleted; hope is lost.	The Breaking Point: Raw willpower runs dry. The emotional engine experiences deep exhaustion, rendering the professional mask unsustainable.
3. Deep Depression Stage	Complete systemic paralysis and total hopelessness.	Total Systemic Failure: The mind enters a state of absolute immobilization and severe behavioral withdrawal, creating a dangerous space where hidden ideation thrives.

desperately searches for an exit from a reality it can no longer manage or endure.

V. THE PROTOCOL FOR RESTORATION AND CRISIS INTERVENTION

Dismantling the internal armor and reversing the path of systemic failure requires a specialized strategy. Traditional clinical interventions often fail when applied to first responders because they clash with the practitioner's deeply ingrained survival mindset of hyper-control.

To break through this resistance, crisis managers and peer-support networks must deploy a precise, multi-phase methodology. This protocol transitions the individual from self-reliance to sustainable restoration (see Figure 3 and Table 4).

1. PHASE 1: OPERATIONAL ASSESSMENT (LISTEN & OBSERVE)

The intake phase rejects invasive, adversarial questioning. Instead, the clinician or peer counselor must **Listen & Observe,** actively monitoring the responder's subtle linguistic cues, behavioral self-reports, and physical appearances. Because first responders are highly trained to project stability, the counselor must look past the uniform to track structural anomalies: changes in sleep hygiene, spikes in dark humor, withdrawal from peer networks, and signs of hyper-vigilant fatigue. The goal is to gather vital diagnostic details while building an unconditional alliance.

2. PHASE 2: BOUNDARY PROTECTION (SIMPLE PRAYER)

When dealing with an individual in the midst of spiritual or emotional collapse, forcing immediate compliance, artificial optimism, or intense corporate reflection is counterproductive. The protocol dictates a transition into **Simple Prayer** and intentional boundary protection.

The counselor must not force worship or demand performance from a fragile soul that is completely out of fuel. Instead, the intercessor builds a protective shield *around* the responder, enlisting targeted prayer and support for the counselor or peer leader. This shifts the operational burden away from the traumatized individual, allowing their nervous system to step out of high alert survival mode.

3. PHASE 3: NARRATIVE EXPOSURE (HOLY CATHARSIS)

True freedom requires bringing hidden trauma out of darkness. **Holy Catharsis** is the structured space where the responder is given permission to lay down the mask and voice their unfiltered reality.

This phase facilitates the release of buried grief, unprovoked pain, and hidden resentments (such as historical bitter root dynamics or operational shock) without fear of institutional judgment or professional penalty. By speaking the unvoiced story aloud, the practitioner breaks the power of denial, exposing the root causes of their anger and trauma to the light of truth.

4. PHASE 4: BOLD CONFIDENCE AND CROSS-DEPENDENCY

The final phase requires a complete rejection of passive helplessness. The clinician and practitioner step into **Bold Confidence,** firmly declaring complete healing and breaking the generational and environmental chains of trauma.

This culminates in a paradigm shift: **Cross-Dependency.** The warrior abandons self-preservation and the exhausting illusion of self-reliance, choosing instead to utter the definitive words of freedom: *"Over to you, Lord."* By surrendering the heavy internal armor at the feet of the King, the first responder replaces their fragile, performance-based defense system with a daily resurrected heart anchored securely in grace.

VI. CONCLUSION

The internal armor built by law enforcement professionals and first responders is a highly adaptive short-term survival mechanism that functions as a long-term psychological cage. As demonstrated through this practitioner case study, the persistent demands of a volatile environment frequently drive individuals into a destructive cycle of *Performance Drift*. When officers

Figure 3.

THE WARFARE AND DELIVERANCE PROTOCOL

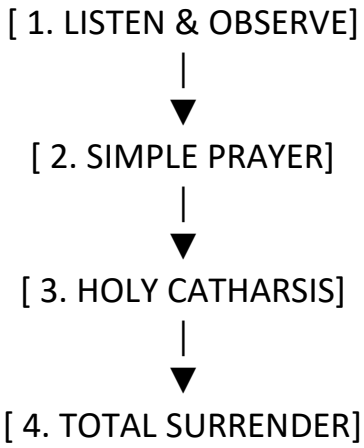


Table 4.

THE WARFARE AND DELIVERANCE PROTOCOL

Phase	Operational Manifestation	Core Dynamic
1. Listen & Observe	Track linguistic self-reports and outward appearances.	The Assessment: Actively monitoring baseline shifts, language, and physical indicators behind the badge to detect hidden pressure.
2. Simple Prayer	Protect boundaries and deliberately avoid forced performance.	The Boundary Shield: Removing spiritual demands from a depleted nervous system while establishing protective cover around the practitioner.
3. Holy Catharsis	Bring the hidden, unvoiced story completely to light.	The Narrative Exposure: Creating a secure, judgment free space to speak the unspoken trauma, stripping secrets of their destructive power.
4. Total Surrender	Release absolute control and anchor deeply in grace.	The Sovereign Release: Transitioning from isolating self-reliance to total dependency on the cross, establishing a daily resurrected heart.

attempt to absorb systemic chaos using raw willpower, they inevitably suffer *Unholy Burden-Bearing,* resulting in total energy depletion and an eventual descent into the *Deep Depression Stage.*

The tragic loss of a colleague highlights the urgent need for a shift in how the emergency services community addresses internal crises. Institutional cultures must look past the badge to recognize the vulnerable human being underneath. By implementing structured intervention protocols centered on active tracking, protective boundaries, narrative exposure, and complete surrender, crisis intervention specialists can successfully dismantle the hidden strongholds of the heart. True resilience is not achieved by building thicker walls of denial, but by possessing the profound bravery to lay the armor down, transforming broken warriors from silent survivors into restored thrivers.

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SELF-CARE FROM PSALM 23

CHAPLAIN GARY R EVANS

This Psalm is probably the most beloved, memorized, or quoted Psalm in the Holy Bible. Many have expounded on its interpretations and applications for centuries with good reason as it has been a premier source of comfort for many for just as long.

Any of you who have taken a training with me, or worked with me, or have been deployed with me know how passionate I am about caring for the care-givers; about you taking care of you; in short…self-care. It is to this point that I believe God has shown principles of self-care that will be beneficial to those who read this ministerial missive (see diagram below).

Faith – "The Lord is my shepherd" – the foundation of self-care is faith in and a total commitment to Jesus Christ as personal Lord and Savior…"For no one can lay any foundation other than the one already laid, which is Jesus Christ." – 1Corinthians 3:11; Jesus Christ is absolutely the firm faith Foundation to holistic health – "Therefore thus says the Lord GOD, "Behold, I am laying in Zion a stone, a tested stone, A costly cornerstone for the foundation, firmly placed. He who believes in it (Him) will not be disturbed." – Isaiah 28:16. Consider maintaining a faith life by continual Bible reading and/or study, prayer, and church attendance.

Attitude – "I shall not want" – a positive attitude that truly embraces the fact that …"my God will supply all your needs according to His riches in glory in Christ Jesus." – Philippians 4:19. I recommend creating a daily "Attitude of Gratitude" journal with each date in which you jot down bullet points of anything good that happens to you in that day. Then at night, just before you turn out the lights, thank God for every one of those things. And, when the devil attacks with discouragement, refer back to those good things to remind yourself of the good things God has done for you.

Rest – "He makes me lie down in green pastures" – solid REM sleep with abundant oxygenation is vital to good holistic health and overcoming stress and trauma; recognize that… "It is vain for you to rise up early, To retire late, To eat the bread of painful labors; For He gives to His beloved even in his sleep." – Psalm 127:2. I recommend the reading of the Psalms just before you go to sleep and at any time you may wake up in the middle of the night and can't get back to sleep. I'm a firm believer in Psalm therapy as a soporific (sleep aid) in those waking moments.

Nutrition – "He leads me beside quiet waters…You prepare a table before me" – proper hydration (reduce caffeine, alcohol, sugar intake) and nutrition is paramount to proper stress relief, cognition and brain functioning; water helps to expel adrenaline toxicity; the brain works better when the stomach and hence the body are properly fueled. Be sure your diet has healthy doses of protein.

Exercise – "He guides me in the paths of righteousness for His name's sake; Even though I walk through the valley of the shadow of death" – these phrases indicate physical as well as mental and spiritual exertion; in order to fully traverse a valley, it presupposes the fact that there had to be a rather arduous (feels deathly) descent into the valley and an equally arduous (again…feels deathly) ascent out of the valley; such nonetheless can provide for good muscle tone and cardiovascular functioning; you don't necessarily have to belong to a gym to get good exercise; a good walking regime can be beneficial for all around good health. Practice good deep diaphragmatic breathing exercises such as 'box breathing', etc.

Also, 'exercise' your faith in volunteering to shift your focus from a self-defeating spiral toward a self-determining service to others who may have a shared experience. I have found that such exercise is good for holistic health and is consistent with scripture (2 Corinthians 1:3-7).

Support - "I fear no evil, for You are with me; Your rod and Your staff, they comfort me." – having a good support system is vital for self-care; but the people

chosen must not be just “yes” people; they must be those trusted to provide corrective guidance when necessary; they must be those like Moses’ father- in-law, Jethro, who told the leader of an approximately 1.8-million-member congregation: "What you are doing is not good. Surely you and these people with you will wear yourselves out, because the task is too heavy for you. You cannot handle it alone" - Exodus 18:17-18

Problem-solving leading to self-control - "in the presence of my enemies" - there are four main categories of things that are detrimental to physical, emotional, mental, and spiritual health and therefore are the enemies of body, soul, mind, and spirit; they are namely: sickness, sorrow, stress, and sin. Unfortunately, these are also inescapable in life. Therefore, they must be dealt with or worked through not just “one day at a time” but one moment at a time. Take care of what’s in the forefront at the moment. The best way to eat grandma’s apple pie (to use a positive analogy) is to eat it one piece at a time. To try to eat it all in one bite will just yield “pie in the face!” May it be remembered that: "God has not given the spirit of fear, but of power, love, and soundness of mind (self-discipline)" - 2 Timothy 1:7

In healthcare, be it in the physiological, psychological, psychiatric or spiritual arenas, obtained clinical results are often then cast in terms of “outcomes”. May God thus grant the best outcomes:

Spiritually - "He restores my soul; And I will dwell in the house of the LORD forever." – suggesting a saving faith in and sustaining grace in spirit by the propitiation (atonement) of the Lord Jesus Christ

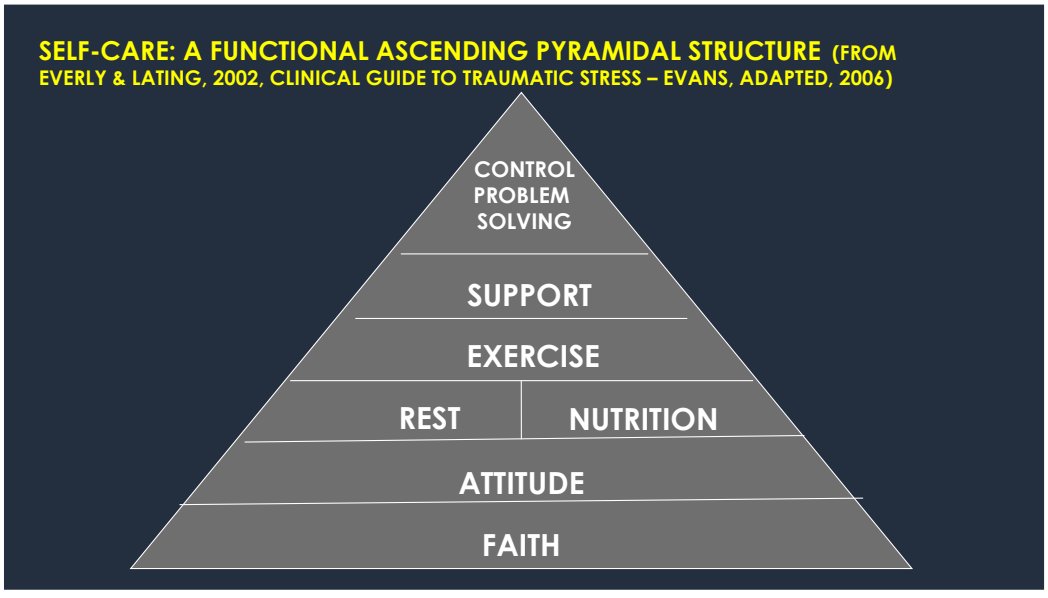
Mentally – "He anoints my head with oil" – suggesting soundness of mind (cognition) and brain (function) via the principles of the Word of God and the mighty power of God

Emotionally - "Surely goodness and lovingkindness will follow me all the days of my life"– suggesting serenity and solace of soul via the presence of the Holy Spirit

Physically - "My cup overflows" – suggesting supply, sustenance, and soundness of body via the provisions, protections, and preservations of God

Table 1.

Self-Care: A Functional Ascending Pyramidal Structure



HOW UN(DER)TREATED TRAUMATIC STRESS CONTRIBUTES TO THE BLACK & BROWN SCHOOL-TO-PRISON PIPELINE

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THE HOLISTIC HEALING SOURCE FOR MARGINALIZED SOCIETY

ABSTRACT

This paper examines the "school-to-prison pipeline" affecting Black and Brown youth, arguing that its foundational catalyst is unaddressed complex trauma stemming from systemic disenfranchisement. From the dual perspective of a pastoral counselor and trauma specialist, the author explores how historical redlining, chronic poverty, and community violence create an ecological reality of traumatic stress. This chronic environment neurologically wires marginalized children for survival rather than compliance. This baseline hyperarousal is exacerbated by a pronounced healthcare gap, characterized by spatial inequities in mental health resources and deep-seated cultural stigmas against psychological care.

Consequently, traumatized youth enter under-resourced, zero-tolerance school environments where trauma-induced dysregulation is frequently mislabeled and criminalized as defiance. Rather than receiving clinical support, these students face disproportionate suspensions and expulsions, funneling them directly into a biased, retributive justice system that only further entrenches their trauma. Ultimately, the paper posits that the pipeline functions exactly as historically designed—to control and marginalize. To genuinely dismantle it, society must shift from punitive frameworks to models of systemic healing. This requires robust investments in economic equity, the integration of trauma-informed professionals in educational settings, and the provision of culturally competent, accessible mental healthcare that honors both science and spirit.

INTRODUCTION

As a Black, female, doctorally prepared pastoral counselor and professionally certified trauma specialist born and bred in a low income community on the South side of Chicago, I have sat in the sacred, often painful spaces where the human spirit collides with systemic brokenness. I have listened to the stories of Black and Brown youth whose lives have been derailed not by a lack of potential, but by a profound, unaddressed accumulation of traumatic stress. The "school-to-prison pipeline"—the alarming framework through which marginalized children are funneled out of public schools and into the juvenile and criminal justice systems—is often discussed in terms of policy and prejudice. However, to truly dismantle this pipeline, we must understand its foundational fuel: un(der)treated complex trauma birthed from systemic disenfranchisement.

THE ECOLOGY OF TRAUMATIC STRESS IN MINORITY COMMUNITIES

Trauma is not merely a psychological reaction to a single horrific event; for many Black and Brown youths, it is an ecological reality, an inescapable atmospheric condition. This chronic trauma is rooted in deeply entrenched systemic disadvantages that keep the nervous system locked in a perpetual state of "fight, flight, freeze or fawn."

First, the lack of generational wealth, a direct legacy of historical redlining and systemic economic exclusion, strips families of the financial safety nets that buffer against stress. Poverty itself is inherently traumatic. When caregivers are consumed by the sheer survival mechanics of securing food, housing, and basic utilities, their capacity to provide emotional co-regulation for their children is severely strained.

Compounding economic insecurity is the reality of high-crime environments. Exposure to community violence alters the developing brain. A child navigating a neighborhood where violence is a distinct possibility develops a hyper-vigilant nervous system. The amygdala—the brain's threat-detection center—becomes enlarged and overly reactive, while the prefrontal cortex, responsible for emotional regulation and executive functioning, becomes impaired (Porges, 2011). These children are not "defiant"; they are wired for survival, yet they are expected to sit still and learn peacefully in a classroom.

THE HEALTHCARE GAP AND THE BURDEN OF STIGMA

When trauma occurs, the standard societal prescription is psychiatric or psychological intervention. Yet, for Black and Brown communities, accessible, culturally competent, and high-quality healthcare is a glaring void. Systemic inequities mean that mental health resources are often concentrated in affluent, predominantly white zip codes. When services are available, they are frequently underfunded, with long waitlists or prohibitive out-of-pocket costs.

Furthermore, we must address the internal barriers: the cultural stigma against seeking mental health services. Historically, the psychiatric establishment has weaponized diagnoses against Black and Brown bodies, fostering deep, justified generational mistrust (Metzl, 2009). Within many communities of color, particularly in religious contexts, psychological distress has been viewed as a spiritual failing rather than a biological or psychological injury. I often hear variations of, "We don't go to therapy; we take it to the altar." While faith and prayer are profound sources of resilience, relying solely on them while dismissing the need for clinical trauma intervention leaves deep psychological wounds untreated. The stigma of being labeled "crazy" in a society that already heavily prejudices Black and Brown individuals prevents families from seeking the care their children desperately need (Snowden, 2001).

THE CLASSROOM AS AN INTERROGATION ROOM

When these children, carrying the heavy, invisible backpacks of complex trauma and allostatic load (chronic physiological wear and tear), enter underfunded local schools, the tragedy of the pipeline begins. These schools often lack adequate mental health professionals—such as guidance counselors, social workers, and educational psychologists—but are highly equipped with school resource officers (police) and metal detectors.

Traumatic stress manifests behaviorally. A traumatized child experiencing a flashback or a perceived threat may dissociate (appearing disengaged or lazy) or react aggressively (hyperarousal). In a trauma-informed environment, a dysregulated child is met with the question, "What happened to you?" and is offered regulation strategies. However, in under-resourced schools driven by zero-tolerance policies, the child is met with, "What is wrong with you?" (Skiba et al., 2011).

Trauma responses are immediately criminalized. Normal developmental misbehaviors or neurologically driven panic responses are labeled as "insubordination," "defiance," or "disorderly conduct." Consequently, Black and Brown students are suspended and expelled at disproportionately higher rates than their white peers for the exact same infractions (Annamma et al., 2014). Suspension pushes them out of the educational environment and onto the streets, directly feeding the pipeline.

THE FINAL TRAP: AN UNJUST LEGAL SYSTEM

Once a traumatized minority youth is pushed out of the school system and into the hands of law enforcement, they face a legal system that is historically and statistically tainted against them. Implicit and explicit biases within policing, prosecuting, and sentencing mean that Black and Brown youth are more likely to be arrested, tried as adults, and given harsher sentences than white youth committing the same offenses (Alexander, 2010).

The juvenile justice system rarely rehabilitates; it predominantly re-traumatizes. Incarceration strips away any remaining protective factors, subjects the youth to further violence and isolation, and deeply embeds the trauma response. The US prison system is so flawed that recidivism is sky high, and results are poor. This motivated my doctoral research project where I argued the need for trauma informed spirit led

prison programming and reentry services that are holistic in nature. By failing to treat the initial traumatic stress, society virtually guarantees the creation of a "criminal" out of a child who simply needed healing and resources (Mallett, 2016).

CONCLUSION: A CALL FOR SYSTEMIC HEALING

The Black and Brown school-to-prison pipeline is not evidence of a broken system; it is evidence of a system functioning exactly as it was historically designed—to control, marginalize, and punish. As a trauma specialist and pastoral counselor, I assert that we cannot arrest our way out of a public health crisis.

Dismantling this pipeline requires a radical, systemic overhaul. We must invest in generational wealth-building and divest from punitive school policies. We must flood under-resourced schools with trauma-informed counselors rather than law enforcement. We must de-stigmatize mental health care in minority communities by providing culturally competent, easily accessible clinical care that honors both science and spirit. Until we recognize traumatic stress as the bleeding wound at the heart of our most marginalized communities, we will continue to lose our brightest children to the darkness of a prison cell.

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RELIGIOUS TRAUMA, INSTITUTIONAL BETRAYAL, AND THE SENSE OF COHERENCE: A CASE ANALYSIS

RODERICK LOGAN, DPTH, FAAETS

ABSTRACT

Background

Religious or spiritual abuse can produce traumatic stress when authority, attachment, meaning, and community are used to control or silence a person. The injury may be intensified when the institution responsible for protection minimizes the harm, protects the authority figure, or assigns responsibility to the person who was harmed. Research links abuse by religious authorities with betrayal, mistrust, depressive symptoms, spiritual disruption, and difficulty maintaining relationships and religious identity (Ellis et al., 2022; McGraw et al., 2019).

Case

This article presents a fictionalized, illustrative case of Emily Carter, a young woman raised in a non-denominational evangelical church in Grapevine, Texas. Emily disclosed prolonged abuse by a youth pastor who had framed the relationship as spiritual accountability. The church responded by protecting the pastor's ministry and redirecting responsibility toward Emily and her family. The case is analyzed as an example of religious trauma compounded by institutional betrayal.

Analysis

The case is interpreted through a trauma-informed and salutogenic framework using safety, trustworthiness, transparency, agency, autonomy, and Antonovsky's Sense of Coherence: comprehensibility, manageability, and meaningfulness.

Implications

Recovery requires more than symptom reduction or a return to religious participation. It requires truthful naming, protection from further harm, restoration of choice and self-trust, access to safe relationships, and the development of meaning that does not depend on renewed submission to the system associated with the injury.

Keywords: religious trauma; spiritual abuse; institutional betrayal; traumatic stress; salutogenesis; Sense of Coherence; agency; autonomy; trauma-informed care.

INTRODUCTION

Religious communities can provide belonging, moral orientation, social support, and practices that help people interpret suffering. Religion and spirituality can therefore function as important coping resources (Pargament, 1997). The same systems can also become sources of trauma when religious authority is used to control access to relationships, information, identity, or God. Religious or spiritual abuse is not limited to a single harmful act. It may include coercive teaching, misuse of authority, forced disclosure, isolation, shaming, spiritual threats, boundary violations, and institutional

responses that protect the community rather than the person who was harmed.

The research base is developing, and the terminology remains uneven. Ellis et al. (2022) found substantial variation in definitions and methods across empirical studies of religious or spiritual abuse and trauma. Their systematic review nevertheless identified consistent concerns involving entry into and exit from abusive religious communities, the role of religious communities in abuse, negative psychological outcomes, identity change, and treatment. McGraw et al. (2019) similarly identified betrayal, mistrust, disbelief, secrecy, depressive symptoms, and loss of faith or religious belonging among recurrent consequences of abuse by religious authorities.

This article examines a fictionalized case through a trauma-informed and salutogenic lens. It does not establish a diagnosis or generalize from one narrative. It shows how the original abuse and the institutional response can compound traumatic stress. It asks three questions:

1. How can spiritual authority and institutional response compound traumatic stress?
2. How can institutional betrayal be understood through the Sense of Coherence?
3. What practice conditions support recovery without requiring premature reconciliation, forgiveness, or return to the institution associated with the harm?

LITERATURE REVIEW

RELIGIOUS AND SPIRITUAL ABUSE

Religious or spiritual abuse is described in the literature with overlapping terms, including spiritual abuse, religious abuse, religious trauma, spiritual harm, and adverse religious experiences. The terminology is not fully standardized, which complicates comparison across studies (Ellis et al., 2022). Here, religious or spiritual abuse means the misuse of religious or spiritual authority in ways that cause psychological, relational, bodily, or spiritual harm.

The misuse of authority may be overt or gradual. A leader may claim special access to divine knowledge, define disagreement as rebellion, require secrecy, reinterpret boundaries as disobedience, or make continued belonging conditional upon compliance. In such settings, ordinary developmental questions can be reframed as evidence of moral failure. The person may lose confidence in personal perception because the institution has taught that obedience is safer or more faithful than discernment.

Research on abuse by religious authorities indicates that the consequences may include betrayal and mistrust, difficulties in relationships, depressive symptoms, spiritual struggle, and loss of connection to religious institutions (McGraw et al., 2019). Ellis et al. (2022) also found that religious or spiritual abuse can affect identity and the process of entering or leaving religious communities. Perry (2024) emphasizes that survivors often move through processes of recognizing the abuse, telling the story, and redefining spirituality. These processes are not necessarily linear and should not be mistaken for evidence that a survivor has failed to recover.

BETRAYAL TRAUMA AND INSTITUTIONAL BETRAYAL

Betrayal trauma theory proposes that harm is especially disruptive when it is perpetrated by a trusted person or institution on which the individual depends for protection, resources, belonging, or survival (Freyd, 1996). Religious communities may occupy precisely this position. A child, adolescent, or adult may depend on a congregation for family relationships, housing, employment, social identity, spiritual guidance, and access to a broader community.

Institutional betrayal extends this framework to the ways institutions fail to prevent, respond to, or take responsibility for interpersonal trauma (Smith & Freyd, 2014). Institutional betrayal may include ignoring warnings, discouraging disclosure, protecting the accused, punishing the person who reports, concealing relevant information, or returning the person who caused harm to a position of access. This framework is especially relevant to religious trauma because the institution may present itself as a moral authority. A person who discloses harm may therefore experience not only interpersonal betrayal but also a collapse of the

system used to interpret truth, goodness, safety, and God.

Gender and power may also interact in betrayal trauma. DePrince and Freyd (2002) argue that social context shapes how betrayal is experienced, remembered, and interpreted. A gender-informed analysis should not presume that women are the only survivors or that all women experience religious authority in the same way. It should instead examine how gender expectations, obedience norms, sexuality, family roles, and institutional power shape the available choices and meanings in a particular case.

SALUTOGENESIS AND THE SENSE OF COHERENCE

Salutogenesis directs attention toward the conditions that support health rather than focusing exclusively on the origins of disease. Antonovsky (1987) described the Sense of Coherence as a global orientation through which life is experienced as comprehensible, manageable, and meaningful. Reviews have associated a stronger Sense of Coherence with perceived health, particularly mental health, although the construct should not be treated as a simple measure of individual strength (Eriksson & Lindström, 2006, 2007).

Comprehensibility concerns whether events can be understood as structured, explicable, and sufficiently predictable. Manageability concerns whether a person can access resources to meet demands. Meaningfulness concerns whether life and its demands are worthy of investment. The framework is useful for religious trauma because coercive systems may disrupt all three dimensions at once.

Abuse can make experience incomprehensible: the person is told that harmful conduct is spiritual care. Institutional denial can make the environment unmanageable: the person cannot predict whether disclosure will result in protection, punishment, or expulsion. Spiritual betrayal can make life meaningless: the values and practices once used to organize life become associated with danger. A salutogenic response does not deny the injury. It asks what relationships, resources, boundaries, and meanings can help restore orientation without forcing a predetermined spiritual conclusion (Mittelmark et al., 2022).

TRAUMA-INFORMED CARE

A trauma-informed approach recognizes the prevalence and effects of trauma and seeks to avoid retraumatization. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) identifies safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and attention to cultural, historical, and gender issues as central principles. These principles are particularly relevant to religious trauma because the injury often involves power, secrecy, identity, and the misuse of community.

Trauma-informed care does not require an institution to affirm every interpretation of an event without examination. It does require the institution to respond without humiliation, retaliation, coercion, or avoidable ambiguity. It also requires practitioners to distinguish accountability from control, reconciliation from restored access, and forgiveness from the removal of consequences.

CASE METHOD AND ETHICAL CONSIDERATIONS

This article uses an illustrative conceptual case analysis. Emily Carter is a fictionalized subject adapted from the narrative material in *Finding Everland* (Logan, 2026). The case is not a report of an identified client, is not presented as a clinical record, and does not claim to document an actual congregation or individual. The setting—a non-denominational evangelical church in Grapevine, Texas—is used to situate the case within a recognizable community context; it is not intended to describe or evaluate churches in that location as a group.

The analysis applies four interpretive domains: (a) traumatic stress and relational safety, (b) institutional betrayal and power, (c) agency and autonomy, and (d) comprehensibility, manageability, and meaningfulness. Because the case is fictionalized, informed consent and formal human-subjects review were not applicable to the narrative itself. The article nevertheless uses conservative language, avoids diagnostic conclusions, and identifies the case as educational rather than clinical. Any real-world application should include appropriate assessment, attention to mandatory-

reporting requirements, and consultation with qualified professionals.

CASE PRESENTATION: EMILY CARTER

Emily Carter was seventeen when she disclosed that her youth pastor had abused her for three years. She had been raised in a non-denominational evangelical church in Grapevine, Texas, where obedience, respect for spiritual authority, and protection of the church's reputation were treated as moral obligations. She had learned that questioning church leaders could be interpreted as questioning God.

The youth pastor described the relationship as spiritual accountability intended to help Emily become a godly woman. He used religious language about submission and obedience while isolating her from friends and family. The relationship was presented as formative and protective, but its practical effect was to increase secrecy, dependency, and the leader's control over Emily's interpretation of events.

When Emily disclosed the abuse, her parents asked what she had done to encourage it. Their response communicated that the institution's reputation and the pastor's standing mattered more than Emily's safety. The church allowed the youth pastor to resign quietly and provided a recommendation letter. Years later, Emily learned that he was working with teenagers at another church.

That discovery changed her understanding of the injury. The harm was not only the conduct of one person. The surrounding system had created conditions in which authority could operate without meaningful accountability, and the institutional response had redirected responsibility toward the person who disclosed the abuse.

In early adulthood, Emily experienced depressive symptoms, disordered eating, distrust of authority, and difficulty forming healthy attachments. These descriptions are not intended as formal diagnoses. They represent the fictionalized narrative's account of distress and functional disruption. In trauma-informed therapy during her mid-twenties, Emily began to understand how institutional betrayal had compounded the original abuse.

Her recovery required more than deciding whether she would remain connected to organized religion. She needed to learn that her perception could be credible, that boundaries were not rebellion, and that spiritual connection did not require submission to coercive control. She also needed relationships in which trust could develop gradually and without punishment for uncertainty.

CASE ANALYSIS

SAFETY AND TRUST

Safety was violated first. The youth pastor used a position associated with guidance and protection to create secrecy and isolation. The institutional response then failed to restore safety after disclosure. Instead of protecting Emily from further access and examining the pastor's conduct, the church allowed him to leave quietly and continue working with adolescents elsewhere.

Trust was disrupted at multiple levels: trust in the pastor, trust in family members, trust in church leadership, trust in religious language, and trust in Emily's own judgment. We should not interpret this distrust as resistance or lack of faith. It was an understandable adaptation to a setting in which apparent safety and actual safety diverged.

TRANSPARENCY AND INSTITUTIONAL BETRAYAL

The case contains several failures of transparency. The relationship was labeled accountability rather than identified as an abuse of power. The institutional response did not provide Emily with a truthful account of what had occurred, how risk had been evaluated, or why the pastor was permitted to continue working with young people. The recommendation letter further concealed the seriousness of the concern from future communities.

Institutional betrayal occurs when an institution fails to prevent or respond appropriately to trauma in ways that compound the original harm (Smith & Freyd, 2014).

Emily's experience illustrates how this betrayal can be especially destabilizing when the institution claims moral authority. The church was not simply one social setting among many. It was part of the system through which Emily learned to interpret God, morality, authority, family, and belonging.

AGENCY AND AUTONOMY

Agency refers here to the capacity to initiate, direct, and sustain intentional action. Autonomy refers to the right and ability to govern one's decisions, boundaries, body, relationships, and identity. The youth pastor's use of submission language weakened both capacities. Emily's questions were treated as moral problems, and her ability to interpret the relationship independently was narrowed.

Recovery therefore requires more than asking Emily to make better choices. It requires conditions in which choice is safe and effective. A practitioner might offer options about pace, disclosure, contact with religious communities, therapeutic goals, and spiritual practices. The survivor should not have to surrender decision-making in order to receive care.

SENSE OF COHERENCE

COMPREHENSIBILITY

Emily initially struggled to understand how a respected spiritual leader could cause harm while using the language of God. Naming spiritual abuse, coercive control, and institutional betrayal helps organize experiences that previously appeared contradictory. The question changes from "What is wrong with me?" to "What happened, who held power, and how did the system respond?" This shift restores clarity without assigning blame to Emily.

MANAGEABILITY

Manageability requires resources and boundaries, not willpower alone. Relevant resources may include trauma-informed therapy, peer support, legal or advocacy consultation, medical care when needed, safe family members, and relationships outside the institution that caused or compounded the harm. Boundaries may include limiting contact, refusing private meetings with leaders, controlling disclosure, and deciding whether or when to participate in religious practices.

A manageable recovery environment does not require Emily to trust immediately. It provides predictable information, meaningful choice, and support that remains available when she says no. It also makes institutional policies, reporting processes, and consequences transparent.

MEANINGFULNESS

Meaningfulness does not require Emily to describe the abuse as beneficial or to reconcile with the church. It involves reconnecting with values, relationships, and forms of spiritual or secular meaning that do not require self-erasure. Meaning is a living orientation toward what matters, not a fixed explanation that determines what her suffering must mean. It may be found in truth-telling, embodied safety, creative work, community, family, justice, service, or a carefully redefined spiritual life.

This is an important distinction. A salutogenic framework does not convert suffering into a moral lesson or impose a positive ending. It supports a living orientation toward dignity, connection, and purpose while allowing grief and anger to remain truthful.

DISCUSSION

Emily's case illustrates why religious trauma should be understood as a disruption of relationship, meaning, and power rather than as a private failure of belief. The original abuse involved a trusted authority figure. The institutional response then intensified the injury through secrecy, blame, and continued access to adolescents. The case therefore reflects both interpersonal trauma and institutional betrayal.

The analysis is consistent with the literature. Reviews of abuse by religious authorities identify betrayal, mistrust, disbelief, secrecy, depressive symptoms, and spiritual disruption as recurring outcomes (Ellis et al., 2022; McGraw et al., 2019). Betrayal trauma theory helps explain why the injury may be profound when the

person depends on the institution for belonging and meaning (Freyd, 1996). Institutional betrayal theory explains why an inadequate or protective response can become a second layer of trauma (Smith & Freyd, 2014).

The Sense of Coherence adds a complementary account of recovery. The issue is not only Emily's distress. Her ability to make sense of authority, access resources, and find meaningful direction was disrupted. A trauma-informed response can therefore be evaluated by asking whether it increases comprehensibility, manageability, and meaningfulness while protecting safety, trustworthiness, transparency, voice, and choice.

The case also challenges overly individualistic accounts of resilience. Emily's recovery cannot be reduced to her ability to regulate emotions, challenge beliefs, or choose healthier relationships. Institutions and communities shape the conditions under which those actions become possible. A person cannot be expected to develop trust while institutions continue to conceal relevant information or permit unsafe access.

Herman (1992) describes trauma recovery as a movement through safety, remembrance and mourning, and reconnection. The movement described in *Finding Everland* offers a related practice-oriented sequence: identify what was taken, permit truthful lament, test trust carefully, and move toward integration without denying the past. This sequence should not be treated as a universal stage model. Survivors may move in different directions, revisit earlier concerns, or choose not to return to religious community. The value of the sequence is its refusal to confuse healing with premature resolution.

PRACTICE IMPLICATIONS

Practitioners, families, and faith communities responding to religious trauma should:

- Treat disclosures as safety concerns rather than reputation-management problems.
- Provide immediate protection from further access by the alleged perpetrator when appropriate.
- Explain reporting procedures, confidentiality limits, and institutional responsibilities clearly.
- Avoid language that assigns responsibility for abuse to the person who was harmed.
- Distinguish spiritual guidance from coercive control and accountability from surveillance.
- Support agency and autonomy through meaningful choices about pace, disclosure, treatment, and participation.
- Distinguish forgiveness from restored access and reconciliation from accountability.
- Avoid requiring survivors to remain in, return to, or publicly defend the institution associated with the harm.
- Provide access to support outside the institution when institutional trust has been compromised.
- Document institutional decisions and examine whether policies protect people or merely preserve authority.

LIMITATIONS

This article presents a fictionalized conceptual case rather than an empirical case report. It cannot establish prevalence, treatment efficacy, or causal relationships. The case reflects one narrative pattern and does not represent all survivors, religious traditions, evangelical communities, or experiences of spiritual abuse. The setting in Grapevine, Texas, is contextual and fictionalized; no conclusion should be drawn about churches or residents in that location.

The article also applies the Sense of Coherence as a conceptual framework rather than measuring Emily's SOC with a validated instrument. Future research could examine religious or spiritual abuse using mixed methods, survivor-informed measures, longitudinal designs, and greater cultural and denominational diversity. Research should also examine institutional responses, not only individual symptoms.

CONCLUSION

Religious trauma may be intensified when spiritual authority is used to control, when institutional responses conceal danger, and when disclosure is met with blame. Emily Carter's fictionalized case shows how the original abuse and the institutional response can disrupt safety, trust, transparency, agency, autonomy, and meaning at the same time.

A trauma-informed and salutogenic response does not ask survivors to return to what harmed them or to convert suffering into a lesson. It helps restore the conditions under which a person can understand what happened, access resources and boundaries, make meaningful choices, and develop a life oriented toward dignity and connection.

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FROM THE PATROL CAR TO THE THERAPY CHAIR: OCCUPATIONAL CREDIBILITY, TRUST, AND THE THERAPEUTIC ALLIANCE WITH FIRST RESPONDERS

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ABSTRACT

First responders are among the populations least likely to seek mental health care and among the most likely to leave early. Among the reasons most frequently cited are distrust of clinicians who do not understand the work, fear of career consequences, and an occupational culture that frames help-seeking as weakness (Haugen et al., 2017; Karaffa & Koch, 2016). This paper draws on the author's six years as a municipal police officer, more than two decades of clinical practice with first responder and military populations, and long-standing leadership in Critical Incident Stress Management (CISM) to examine how shared occupational experience shapes trust, disclosure, and the therapeutic alliance. The advantages of occupational credibility are described alongside its risks, including assumed similarity, over-identification, boundary strain in small professional communities, and the misuse of self-disclosure. Practical strategies for structuring trust are offered, along with guidance for clinicians who do not share a first responder background. The paper argues that credibility opens the door to treatment but does not substitute for it, and that the elements of trust first responders look for can be learned.

Keywords: first responders, law enforcement, therapeutic alliance, cultural competence, help-seeking, critical incident stress management, self-disclosure

THE TRUST GAP

First responders carry a well-documented burden of occupational trauma. Police officers, firefighters, emergency medical personnel, and dispatchers are exposed repeatedly to death, violence, and human suffering, and a meta-analysis of rescue workers worldwide found a pooled current PTSD prevalence of about 10 percent, well above general-population rates (Berger et al., 2012). Yet exposure alone does not predict who receives care. A consistent finding across the literature is that first responders underuse mental health services (Haugen et al., 2017; Karaffa & Koch, 2016). In the author's clinical experience, those who do enter treatment often leave after only a few sessions.

The barriers are familiar to anyone who has worked with this population. Responders worry that disclosure will reach their chain of command, affect fitness-for-duty status, or cost them their firearm, their promotion, or their career (Haugen et al., 2017). The culture of the work prides itself on self-reliance, emotional control, and the ability to handle what others cannot. And many responders carry a specific skepticism about clinicians themselves: the belief that a therapist who has never worked the job will not understand it, will be shocked by it, or will pathologize responses that are, within the profession, entirely normal (Karaffa & Koch, 2016; Kirschman et al., 2014).

This last barrier is the focus of this paper. It raises a practical question that has received relatively little direct attention: what does a clinician's own occupational background actually change in the treatment room? Peer support programs are built on the premise that shared experience creates trust (International Association of Chiefs of Police [IACP] Psychological Services Section, 2021). Clinicians who come from first responder backgrounds occupy a hybrid position, holding both the lived experience of a peer and

the training and obligations of a licensed professional. That position carries real advantages. It also carries risks that are rarely discussed openly.

The purpose of this paper is to describe both. It draws on the author's experience as a former police officer turned clinician, and on more than two decades of clinical and crisis work with first responder populations, to examine how occupational credibility shapes the alliance, where it can mislead the clinician, and what any clinician, with or without that background, can do to earn the trust this population is slow to give.

AUTHOR POSITIONING

I served as a police officer with the Largo Police Department in Florida from 1993 to 1999. I entered the mental health field after leaving law enforcement, and my doctoral work focused on police officer stress and occupational trauma. I have been affiliated with Critical Incident Stress Management of West Central Florida since 1999 and currently serve as its Clinical Director. My private practice serves first responder and military populations, and I consult with fire departments across Pinellas County (FL).

I offer this history not as a credential but as a lens. The observations in this paper are shaped by the fact that I have stood on both sides of the door: as an officer who had no interest in talking to a therapist, and as a therapist trying to earn the trust of first responders who feel exactly the same way. That dual perspective is the source of whatever insight this paper offers. It is also a source of bias, and part of the work of this paper is to name where that bias can lead a clinician astray.

The clinical examples that follow are composites. Details have been altered and combined from multiple cases so that no example describes an identifiable individual.

WHAT OCCUPATIONAL CREDIBILITY OFFERS

PASSING THE EARLY TEST

Many first responders enter the first session prepared to test the clinician. The test is rarely explicit. It may take the form of a deliberately graphic account delivered early and flatly, a joke that would be considered dark in any other setting, or a question about whether the clinician has ever seen a dead body. The underlying question is whether the clinician can hear the reality of the job without flinching, moralizing, or becoming the person who now needs to be taken care of.

A clinician with a first responder background often passes this test before it is administered. When a client learns that the person across from them has worked the road, the posture in the room frequently changes. The client no longer needs to translate the job, soften it, or protect the clinician from it. In my experience, this shift can compress into a single session what might otherwise take several, and in a population prone to early dropout, those sessions matter.

> Composite example. A veteran patrol sergeant arrived at his first appointment at the insistence of his spouse and spent the first fifteen minutes describing, in detail and without affect, a series of fatal crashes. When he paused, he asked whether I had worked traffic fatalities. I answered that I had, briefly, and asked which of the calls he had just described was the one he still thought about. He named one that he had not described at all. The graphic account had been a test; the unmentioned call was the reason he had come.

SHARED LANGUAGE AND FASTER DISCLOSURE

First responder work carries its own vocabulary, its own dark humor, and its own implicit rules about what is normal. A clinician who shares that culture does not need to stop the client to ask what a term means or why a particular call mattered. More importantly, the clinician is less likely to misread culturally normative responses as pathology. Gallows humor, emotional compartmentalization during a call, and hypervigilance that is adaptive on duty are all features of the work that an outsider may interpret as symptoms before understanding their function (Kirschman et al., 2014; Rowe & Regehr, 2010).

Shared language also helps clients disclose things they believe will not be understood elsewhere: the moral weight of a use-of-force decision, the anger at a system that failed a victim, the guilt of relief when a call turned

out to be someone else's, the cumulative erosion of hundreds of calls that were individually unremarkable. These are experiences that responders often assume a civilian clinician will either minimize or catastrophize.

CREDIBILITY AT THE SYSTEM LEVEL

Occupational credibility operates beyond the individual session. Chiefs, command staff, union leadership, and peer support teams are the gatekeepers who decide which clinicians their personnel are referred to. A clinician whom leadership regards as understanding the job is more likely to be recommended, and a recommendation from a trusted peer or supervisor is one of the most powerful facilitators of help-seeking in this population. In this sense, credibility functions as an access point to an entire workforce, not only to the individual client.

WHAT OCCUPATIONAL CREDIBILITY COSTS

The advantages above are real, and they are the reason peer-informed models have gained traction. But credibility carries risks that are easy to overlook precisely because it feels so helpful. The clinician who shares the client's background is vulnerable to specific errors that a clinician without that background is less likely to make.

ASSUMED SIMILARITY

The most common risk is the assumption that because the clinician has done the job, the clinician knows what the job was like for this client. It does not work that way. Two officers can work the same call and carry away entirely different experiences, shaped by their histories, their roles on the scene, their relationships with those involved, and the meaning they made of it. The phrase "I know what that's like" can close a door that the client was just beginning to open.

Assumed similarity also shows up in clinical formulation. A clinician who remembers their own reactions to a particular kind of call may unconsciously map those reactions onto the client, missing what is actually distinctive about the client's response. Curiosity remains the clinician's most important tool, and shared experience can quietly reduce it.

OVER-IDENTIFICATION AND COUNTERTRANSFERENCE

When a client's experiences resemble the clinician's own, the risk of countertransference increases (Pearlman & Saakvitne, 1995). The clinician may find themselves siding with the client against a department, a prosecutor, or the public in ways that serve their own unresolved experience rather than the client's treatment. They may avoid material that is uncomfortable for them or push toward material they have found meaningful in their own processing. They may feel protective in ways that interfere with appropriate challenge.

Clinicians with first responder backgrounds carry their own exposure histories, and those histories do not stay in the past simply because the clinician changed careers. Ongoing consultation, personal therapy where indicated, and deliberate attention to one's own reactions are not optional for this work. They are the price of admission to using lived experience responsibly.

THE MISUSE OF SELF-DISCLOSURE

Self-disclosure is the mechanism through which occupational credibility is usually established, and it is also where it is most easily misused. A qualitative meta-analysis of 21 studies found that therapist self-disclosure was most often followed by positive processes, including a strengthened therapeutic relationship (Hill et al., 2018). In practice, disclosure tends to help most when it is infrequent, brief, relevant to the client, and quickly returned to the client's experience. It becomes harmful when it shifts attention to the clinician, burdens the client with the clinician's material, or turns the session into a comparison of war stories.

In practice, I have found it useful to disclose the fact of my background, often before treatment begins, and to disclose very little of its content. Clients generally do not need to know what I experienced; they need to know that I am unlikely to be shocked by what they experienced. A useful test before any disclosure is to ask whose need it serves. If the answer is the clinician's, it should be withheld.

Composite example. A firefighter describing a pediatric fatality asked, partway through, whether I had ever worked a call involving a child. I recognized a pull to share a specific memory. Instead, I said that I had, that those calls stay with people in a particular way, and asked what about this one had stayed with him. He later said that he had been bracing for me to tell him my story, and that he was relieved I did not.

BOUNDARIES IN SMALL COMMUNITIES

First responder communities are small, overlapping, and interconnected. A clinician with a law enforcement background may know a client's supervisor, have trained with a client's former partner, or encounter clients at memorial services, training events, or CISM deployments. These overlaps are often unavoidable, and they are not inherently harmful, but they require explicit management (Schank & Skovholt, 2006). Clients need to know in advance how the clinician will handle chance encounters, what the clinician will and will not acknowledge publicly, and how the clinician will protect their confidentiality within a network where a great deal is known informally.

Clinicians who also serve in consulting, training, or crisis-response roles with the same agencies that employ their clients must be particularly careful to keep those roles distinct. A clinician who provides a group debriefing for a department on Tuesday may be seeing one of its members individually on Thursday. The client needs clear assurance that nothing from the individual work flows back to the agency.

THE LIMITS OF TRANSFERABILITY

Finally, occupational credibility is narrower than it appears. A former police officer is not a firefighter, a paramedic, a dispatcher, a corrections officer, or a service member. Each discipline has its own culture, stressors, and sources of meaning, and even PTSD prevalence varies by occupational group (Berger et al., 2012). Dispatchers, for example, often carry the trauma of calls they hear but never see resolved, an experience with little parallel to patrol work. Research with 911 telecommunicators shows that duty-related trauma can produce PTSD symptoms without direct physical exposure to the scene (Lilly & Pierce, 2013; Pierce & Lilly, 2012). Credibility also erodes with time; a clinician who left the field years ago may be working from a picture of the job that no longer matches current policies, technology, or public scrutiny. Clinicians with first responder backgrounds need to hold their own experience as one reference point among many, not as a universal key.

STRUCTURING TRUST IN PRACTICE

Whether or not a clinician shares a client's background, several practices consistently support trust with first responders. These practices matter more than any single credential, and they are available to every clinician.

LEAD WITH CONFIDENTIALITY

Confidentiality is the first and largest barrier for most first responders, and it should be addressed directly in the first contact, not buried in intake paperwork. Clients need a plain-language explanation of what stays private, what the legal limits of confidentiality are, and how the clinician's role differs from fitness-for-duty evaluators. If the clinician has any contract or consulting relationship with the client's agency, that relationship should be disclosed and its boundaries explained. Many responders arrive with specific fears, such as whether seeking therapy will be reported, whether it will affect their ability to carry a firearm, or whether a diagnosis will follow them. These fears deserve specific, accurate answers.

RETURN CONTROL TO THE CLIENT

First responders spend their working lives managing situations they did not choose and cannot fully control. Treatment that feels like one more imposed procedure is unlikely to hold them. Offering choices about pacing, focus, and method communicates respect and restores a measure of control. Many clients are reluctant to narrate traumatic material in detail, particularly early in treatment. Approaches such as Accelerated Resolution Therapy (ART) and Eye Movement Desensitization and Reprocessing (EMDR) can allow processing of traumatic memories without requiring the client to describe them fully aloud, which can be a meaningful point of entry for

clients who are unwilling to talk through the worst of what they have seen (Kip et al., 2013; Shapiro, 2018). Somatic and skills-based approaches can build regulation capacity before trauma processing begins.

BRIDGE CRISIS RESPONSE AND ONGOING CARE

For many first responders, a critical incident debriefing or peer support contact is the first encounter with anything resembling mental health support. CISM is designed as crisis intervention, not psychotherapy, and it is not intended to replace ongoing clinical care for those who need it (Mitchell & Everly, 2023). One of the most valuable roles a clinician can play within a crisis response system is as a trusted bridge: someone responders meet at a debriefing and can later call directly. When the clinician a responder meets in a crisis setting is also available for follow-up care, a significant barrier to referral disappears. This bridge must be managed with care, keeping group crisis work and individual treatment clearly separate, as described above.

BE CONSISTENT

Trust in this population is built more by behavior over time than by any single intervention. Returning calls promptly, keeping appointments, being direct about what the clinician does and does not know, and following through on what was said all communicate reliability. First responders are trained to read people quickly and to notice inconsistency. A clinician who says one thing and does another will be discounted, regardless of background.

GUIDANCE FOR CLINICIANS WITHOUT FIRST RESPONDER BACKGROUNDS

It would be easy to read the preceding sections as an argument that only former responders should treat responders. That is not the argument of this paper, and it would be both impractical and wrong. The number of clinicians with first responder backgrounds is far smaller than the need, and many of the most effective clinicians working with this population have never worn a uniform.

What first responders are looking for in a clinician is not, in the end, shared history. It is a set of qualities that shared history tends to signal: that the clinician will not be shocked, will not judge, understands the culture well enough not to pathologize it, respects the client's competence, and will protect their confidentiality. Each of these qualities can be demonstrated without a first responder background.

Clinicians can build cultural competence deliberately. Ride-alongs, sit-alongs with dispatch, attendance at department training, and participation in CISM or peer support team training offer direct exposure to the work (Kirschman et al., 2014). Reading first-person accounts and occupational research builds vocabulary and context. Consultation with colleagues who have first responder backgrounds can help with formulation.

Equally important is what not to do. Clinicians without first responder backgrounds sometimes overcompensate by adopting the culture's language or humor in ways that read as inauthentic. Responders tend to respect honesty about the limits of one's experience far more than an attempt to seem like an insider. A statement such as "I haven't done your job, so I'll need you to tell me what that was like, and I won't be shocked by it" is often more effective than any claim to understanding.

Perhaps most importantly, clinicians without these backgrounds are not vulnerable to the specific risks described earlier. They are less likely to assume similarity, less likely to over-identify, and less likely to be drawn into comparison. Their outsider position, handled well, can allow a kind of curiosity that insiders must work harder to maintain.

IMPLICATIONS FOR TRAINING AND RESEARCH

Several implications follow for the field. First, graduate training and continuing education in trauma should include explicit content on first responder culture, not as a niche specialty but as a core competency for clinicians likely to encounter this population. Second, clinicians with first responder backgrounds would benefit from training that directly addresses the risks of lived-experience practice, including self-disclosure, over-identification, and multiple relationships, in the same way that peer support programs train peers on

the boundaries of their role (IACP Psychological Services Section, 2021).

Third, the questions raised in this paper deserve empirical study. To the author's knowledge, little research has directly examined whether clinician occupational background affects alliance strength, early dropout, or treatment outcomes among first responders. Studies comparing alliance and retention across clinicians with and without first responder backgrounds, and examining which specific clinician behaviors predict trust, would give the field a stronger basis for training and referral decisions than the practice-based observations offered here.

CONCLUSION

Occupational credibility opens doors. For clinicians who have worked as first responders, it can shorten the early testing period, speed disclosure, and create access to agencies and personnel who might otherwise never seek care. But credibility is a starting point, not a treatment. It carries risks of assumed similarity, over-identification, misused self-disclosure, and boundary strain, and it transfers less completely across disciplines and eras than it seems to.

The deeper lesson, from both sides of the door, is that what first responders need from a clinician can be learned. They need someone who will not flinch, will not judge, will protect their privacy, will respect their competence, and will show up consistently. Some clinicians arrive with part of that already established. Every clinician can build it. The trust gap between first responders and mental health care will not be closed by recruiting former responders into the field alone. It will be closed when clinicians of every background learn to earn that trust deliberately.

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THE GEOGRAPHY OF CHILDHOOD TRAUMA: STRUCTURAL INEQUALITY, POLITICAL GEOGRAPHY, AND RURAL DEVASTATION IN THE UNITED STATES

SAMANTHA PARNHAM, BCBA, LBA

ABSTRACT

BACKGROUND: Childhood trauma exposure varies substantially across geographic contexts, yet existing research treats trauma as unidimensional while neglecting political and structural determinants. This study examines whether childhood trauma clusters systematically by political geography and racial composition across U.S. counties.

METHODS: We analyzed county-level data (n=3,107) on five trauma indicators—child poverty, single-parent households, food insecurity, homicide, and drug overdose—merged with political affiliation (2020 and 2024 presidential elections averaged), rural/urban classification, racial composition, and SNAP enrollment. Counties were classified into four types: Rural Republican (56.6%), Urban Republican (27.7%), Urban Democrat (10.2%), and Rural Democrat (5.5%). We employed Latent Profile Analysis to identify natural trauma clusters, t-tests and ANOVAs for group comparisons, regression models with interactions to test racial composition effects, and intraclass correlations to quantify regional clustering

RESULTS: Latent Profile Analysis identified six distinct trauma profiles strongly associated with county type ($\chi^2(15)=318.37$, $p<.001$, Cramér's $V=0.285$). Critically, 34.5% of Rural Democratic counties—encompassing the Black Belt, Appalachia, and Native American reservations—fell into a "Multi-Dimensional Crisis" profile elevated on all five indicators simultaneously, compared to only 0.9% of Urban Republican counties (38-fold difference). Rural Democratic counties exhibited the highest trauma levels across all indicators: 26.0% child poverty versus 16.0% in Urban Republicans ($d=1.23$, $p<.001$), 34.7% single-parent households versus 22.4% ($d=1.28$, $p<.001$), and 18.5 homicides per 100,000 versus 6.0 ($d=2.18$, $p<.001$). Contrary to predictions, the correlation between % Black population and violence was strong in both Urban Republican ($r=0.718$, $p<.001$) and Urban Democratic ($r=0.827$, $p<.001$) contexts, with the difference statistically significant ($Z=-3.75$, $p<.001$), suggesting residential segregation operates universally rather than being buffered by suburban affluence. The SNAP enrollment gap between Republican and Democratic counties widened rather than narrowed under extreme poverty (5.3 to 67.3 per 1,000, 12.7-fold increase), indicating political culture's influence persists even when survival is at stake. Spatial analysis revealed extraordinary regional clustering: 92-98% of trauma variance occurred between rather than within states (ICCs: food insecurity 98.5%, child poverty 97.0%, single-parent households 96.8%), with three distinct crisis zones identified (Mississippi Delta, Appalachia, Native regions).

CONCLUSIONS: Childhood trauma in America follows deep structural patterns shaped by political geography, historical legacies, and regional economic forces rather than being randomly distributed or primarily individually determined. Rural Democratic counties experience multi-dimensional devastation reflecting compound disadvantage from historical extraction, oppression, and economic abandonment. Residential segregation produces elevated violence in all urban contexts regardless of political orientation, demonstrating systemic racism's pervasive effects. Geographic location accounts for over 90% of trauma variance, suggesting that where a child is born determines trauma exposure more powerfully than individual or family characteristics. Current safety net programs, while utilized, cannot

overcome these structural forces. Findings indicate that geographically-targeted, structurally-informed interventions addressing regional trauma profiles may be more effective than uniform national approaches.

KEYWORDS: Childhood trauma; adverse childhood experiences; political geography; residential segregation; rural poverty; SNAP; spatial clustering; health disparities

INTRODUCTION

A child born in Bullock County, Alabama—a majority-Black rural county in the heart of the Black Belt—faces a fundamentally different childhood than a child born in affluent Fairfax County, Virginia, just outside Washington, D.C. The Bullock County child has a 71% chance of living in a single-parent household, experiences a homicide rate of 21 per 100,000, and faces a 40% child poverty rate. The Fairfax County child encounters none of these risks at such elevated levels. This is not random variation—it reflects deep structural patterns in how childhood trauma is distributed across American geography.

The Adverse Childhood Experiences (ACEs) literature has established that childhood trauma—including abuse, neglect, household dysfunction, and community violence—predicts adult health, economic, and social outcomes across the lifespan (Felitti et al., 1998; Anda et al., 2006). A robust body of research demonstrates dose-response relationships: each additional ACE increases risks for depression, substance abuse, heart disease, and early mortality (Hughes et al., 2017). However, this literature suffers from a critical limitation. It treats trauma as a unidimensional construct—a composite score aggregating diverse experiences—while neglecting the geographic, political, and structural contexts that produce these experiences. This approach obscures vital variation: different places may experience fundamentally different types of trauma, requiring different policy responses.

Recent research has begun documenting geographic variation in childhood adversity. Slopen et al. (2016) found that the poorest children experience at least twice the prevalence of cumulative adversity compared to the wealthiest, while Crouch et al. (2019) demonstrated higher ACE prevalence in rural areas. Yet no research has examined whether political geography—the intersection of rural/urban location and Republican/Democratic political orientation—shapes trauma patterns. This gap is consequential: Republican and Democratic counties differ dramatically in political culture, policy implementation, historical trajectories, and economic structures. Do these differences produce distinct trauma ecologies?

Moreover, political geography increasingly shapes access to safety net programs. Preliminary analyses suggest that Republican counties enroll fewer SNAP (Supplemental Nutrition Assistance Program, formerly Food Stamps) recipients than Democratic counties at equivalent poverty levels, potentially reflecting stigma around help-seeking or administrative barriers (Herd & Moynihan, 2018; Soss et al., 2011). Understanding whether Republican and Democratic counties face different types and levels of trauma is essential for explaining program utilization gaps and designing effective interventions.

This study addresses these limitations by examining how childhood trauma clusters geographically and politically across 3,107 U.S. counties. Using county-level data on five trauma indicators—economic deprivation (child poverty), family structure (single-parent households), food insecurity, community violence (homicide), and substance crisis (drug overdose)—we test whether trauma profiles differ systematically by rural/urban location and Republican/Democratic political orientation. Our analytical approach progresses from identifying natural trauma clusters (Latent Profile Analysis) through testing specific hypotheses about urban segregation, rural devastation, and safety net utilization to quantifying regional spatial clustering.

THEORETICAL FRAMEWORK: A STRUCTURAL-GEOGRAPHIC MODEL

We propose a structural-geographic model of trauma clustering that integrates insights from environmental

justice, political economy, and urban sociology (see Figure 1.)

This framework posits that contemporary trauma patterns reflect historical legacies operating through economic and social structures to produce distinct trauma profiles, which in turn elicit different policy responses. Three mechanisms drive trauma clustering:

MECHANISM 1: SYSTEMIC RACISM AND URBAN RESIDENTIAL SEGREGATION

Decades of discriminatory housing policy—redlining, restrictive covenants, exclusionary zoning, urban renewal—concentrated poverty, violence, and family disruption in majority-minority urban neighborhoods (Massey & Denton, 1993; Rothstein, 2017; Sampson, 2012). These neighborhoods, typically located in Democratic-voting cities, experience higher community violence due to concentrated poverty and disinvestment, higher rates of single-parent households due to mass incarceration and economic precarity, and lower wealth accumulation limiting intergenerational mobility.

Crucially, we examine whether this pattern manifests differently in Urban Democratic versus Urban Republican counties. Urban Republican counties (predominantly affluent suburbs) have smaller Black populations that may be more residentially integrated and economically secure. Urban Democratic counties (diverse city centers) have larger Black populations experiencing concentrated disadvantage. We test competing theories: does residential segregation operate universally (producing similar % Black-violence relationships in both contexts), or do affluent suburbs provide buffers that weaken or eliminate these associations? This question has profound implications for understanding whether systemic racism's effects can be modified by local context or persist regardless of political geography.

MECHANISM 2: RURAL ECONOMIC ABANDONMENT

Deindustrialization, agricultural consolidation, coal industry collapse, and resource extraction exhaustion left many rural areas—especially in the Black Belt, Appalachia, and Native American reservations—with multi-generational poverty and limited economic opportunity (Case & Deaton, 2020). These regions, which often vote Democratic despite their rural character, experience distinct trauma profiles: extreme economic deprivation (child poverty rates exceeding 40% in some counties), community violence stemming from historical racial terror (Black Belt) or resource conflicts and colonial violence (reservations), substance abuse crises (particularly the opioid epidemic in Appalachia) as responses to economic despair, and food insecurity despite proximity to agricultural production.

These three regions—the Black Belt, Appalachia, and Native reservations—differ in racial composition, historical origins, and dominant trauma types, yet share common features: rural location, economic abandonment, historical oppression or extraction, and Democratic voting patterns. We test whether these "Rural Democratic" counties constitute a distinct crisis characterized by multi-dimensional trauma—simultaneous elevations across multiple indicator—representing compound disadvantage that single-issue policies cannot address.

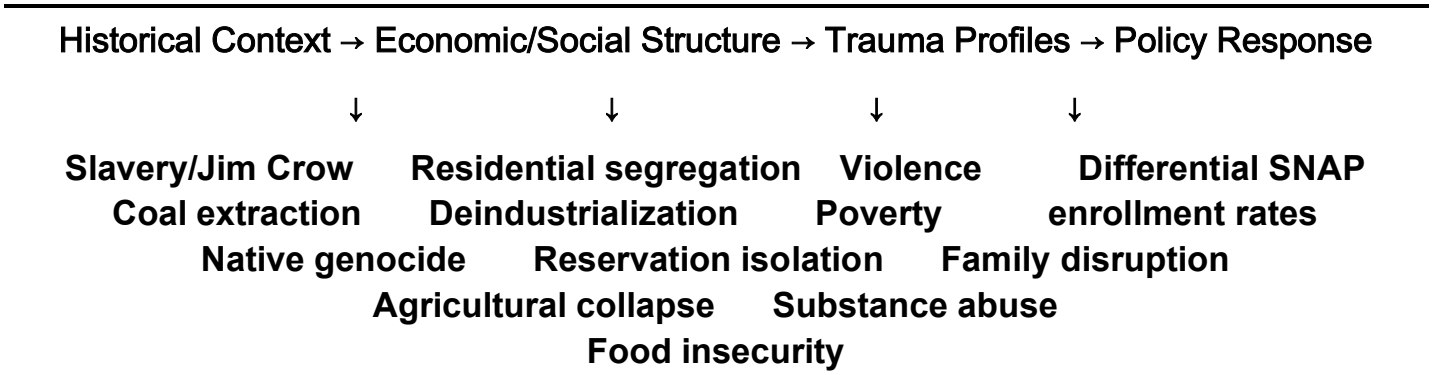
MECHANISM 3: POLITICAL ECONOMY OF PLACE

Political culture may shape both the types of trauma communities experience and their responses to it. Republican political culture emphasizes self-reliance, personal responsibility, and limited government, potentially creating stigma around safety net participation even when families face severe hardship (Soss et al., 2011). This may result in lower SNAP enrollment despite equivalent need, reduced help-seeking for family issues (affecting reporting and visibility), and emphasis on "dignified" struggles where certain hardships (like food insecurity) are seen as universal rather than shameful

Democratic political culture, conversely, may normalize safety net participation, reducing stigma and resulting in higher service utilization even at moderate need levels. However, a critical question remains: Do these

Figure 1.

THEORETICAL FRAMEWORK: A STRUCTURAL-GEOGRAPHIC MODEL



cultural barriers persist under extreme hardship? The "extreme hardship hypothesis" suggests that when trauma becomes unbearable—when child poverty exceeds 40%, when violence ravages communities—survival needs should override political identity. If true, the SNAP enrollment gap between Republican and Democratic counties should narrow in high-trauma contexts. Testing this hypothesis reveals whether political culture's influence on help-seeking is fundamental or conditional.

PREVIEW OF KEY FINDINGS

Our analyses reveal that childhood trauma in America is profoundly shaped by geography, with patterns more striking than anticipated. We identify six distinct trauma profiles through Latent Profile Analysis, with profile membership strongly associated with county type ($\chi^2(15) = 318.37$, $p < .001$). Most dramatically, 34.5% of Rural Democratic counties fall into a "Multi-Dimensional Crisis" profile—simultaneously elevated on all five trauma indicators—compared to only 0.9% of Urban Republican counties, representing a 38-fold difference.

However, some findings challenge our theoretical predictions. The relationship between % Black population and violence is strong in both Urban Republican ($r = 0.718$) and Urban Democratic ($r = 0.827$) contexts, suggesting that residential segregation's effects operate universally rather than being buffered by suburban affluence. Additionally, the SNAP enrollment gap between Republican and Democratic counties does not narrow under extreme hardship as predicted; rather, it widens dramatically (from 5.3 to 67.3 per 1,000), suggesting that political culture's influence persists even when survival is at stake.

Perhaps most strikingly, spatial analysis reveals that 92-98% of trauma variance occurs between states rather than within them, indicating that regional economic and historical forces overwhelm local variation. These findings demonstrate that where a child is born—Mississippi Delta versus suburban Connecticut, Appalachian coalfield versus California coast—determines trauma exposure more powerfully than individual or family characteristics.

RESEARCH QUESTIONS

Building on this framework, we examine seven research questions:

RQ1: Do trauma profiles cluster by political geography (rural/urban × Republican/Democrat)? We hypothesize that counties cluster into distinct trauma profiles, with Rural Democratic counties disproportionately in a "multi-dimensional crisis" class and Urban Republican counties in a "low trauma" class.

RQ2: Which specific trauma types differentiate county types, and at which geographic scales (urban versus rural)? We predict that Urban Democratic counties have higher rates of single-parent households and community violence, while rural counties show higher poverty and food insecurity.

RQ3: Within urban counties specifically, do racial composition and residential segregation explain why Democratic counties have higher trauma? Is the relationship between % Black and violence weaker in Republican suburbs? We test whether affluent suburbs provide buffers against segregation's typical effects.

RQ4: Are Rural Democratic counties uniquely devastated across multiple trauma dimensions, representing a distinct crisis? We predict these counties show the highest trauma levels on all five indicators simultaneously, reflecting compound disadvantage.

RQ5: Do different trauma types associate differently with SNAP enrollment, and does political affiliation moderate these relationships? We examine whether correlations between trauma and SNAP utilization differ by political context.

RQ6: Does the SNAP enrollment gap between Republican and Democratic counties narrow under extreme hardship, or do political barriers persist? We test the "extreme hardship hypothesis" that survival needs override political identity.

RQ7: Do trauma types exhibit geographic clustering beyond state boundaries, suggesting regional economic and historical forces? We quantify spatial

autocorrelation to assess whether trauma reflects regional versus state-level determinants.

CONTRIBUTION AND IMPLICATIONS

This study makes three primary contributions. First, it demonstrates that childhood trauma is not randomly distributed or primarily individually determined but follows deep structural patterns shaped by geography, political economy, and historical legacies. Where a child is born matters profoundly, with geographic location accounting for over 90% of trauma variance.

Second, it identifies Rural Democratic counties—spanning the Black Belt, Appalachia, and Native American reservations—as experiencing a distinct crisis characterized by multi-dimensional trauma. These counties, comprising just 5.5% of U.S. counties but including some of America's most distressed communities, receive limited attention in mainstream poverty research yet show trauma levels rivaling or exceeding those of urban centers.

Third, it reveals that some structural forces (residential segregation, regional economic abandonment) operate more universally than anticipated, while others (political culture's influence on help-seeking) are more context-dependent. These findings have direct implications for policy: geographically-targeted interventions addressing specific regional trauma profiles may be more effective than uniform national approaches.

The paper proceeds as follows. Section 2 reviews relevant literature on geographic variation in adversity, residential segregation, rural poverty, safety net utilization, and spatial clustering. Section 3 describes our data sources, measures, and analytical strategy. Section 4 presents results for each hypothesis systematically. Section 5 discusses theoretical implications, policy recommendations, limitations, and future directions. Results will inform both academic understanding of trauma's structural determinants and practical strategies for geographically-targeted intervention in America's most distressed communities.

LITERATURE REVIEW

The Adverse Childhood Experiences (ACEs) framework has fundamentally shaped our understanding of how early-life adversity affects long-term health and social outcomes (Felitti et al., 1998). However, existing research predominantly treats childhood trauma as an individual-level phenomenon, focusing on cumulative exposure scores while neglecting the geographic, political, and structural contexts that produce these experiences. This study addresses this gap by examining how childhood trauma clusters geographically and politically across U.S. counties, with particular attention to the intersection of place, race, and political economy.

GEOGRAPHIC VARIATION IN CHILDHOOD ADVERSITY

Recent research has begun documenting substantial geographic variation in childhood adversity exposure. Slopen et al. (2016), analyzing National Survey of Children's Health data, found that the poorest children experienced at least twice the prevalence of cumulative adversity compared to the wealthiest, with these disparities larger than racial differences. Crouch et al. (2019) extended this work by demonstrating that adverse childhood experiences were significantly more prevalent among rural children, with rurality, poverty, and race emerging as key predictors. Curtis, Voss, and Long (2012) employed spatial regime regression to show that child poverty exhibits substantial spatial differentiation by county, with local racial/ethnic composition and economic structure serving as primary drivers.

Despite this growing evidence of geographic clustering, existing research suffers from three critical limitations. First, studies focus almost exclusively on urban-rural distinctions or socioeconomic gradients, ignoring political geography entirely. No published research examines whether Republican and Democratic counties—which differ dramatically in political culture, policy implementation, and historical trajectories—experience different types or patterns of childhood trauma. Second, existing work treats geography as a control variable rather than a central organizing principle. Studies adjust for county characteristics statistically but do not theorize how place produces trauma through specific historical, economic, and political mechanisms. Third, the literature lacks comprehensive analyses examining multiple trauma dimensions simultaneously. Most studies focus on single outcomes (poverty, maltreatment, ACEs scores)

rather than investigating whether different places experience fundamentally different trauma profiles.

This study addresses these gaps by employing Latent Profile Analysis to identify natural trauma clusters across five dimensions—economic deprivation, family structure, food insecurity, community violence, and substance crisis—and testing whether these profiles cluster systematically by political geography. We theorize that Rural Democratic counties (including the Black Belt, Appalachia, and Native American reservations) and Urban Republican counties (affluent suburbs) represent fundamentally different trauma ecologies requiring distinct policy responses.

RESIDENTIAL SEGREGATION, RACE, AND URBAN VIOLENCE

The relationship between racial composition, residential segregation, and violence has been extensively documented in urban sociology. Massey and Denton's (1993) landmark work American Apartheid demonstrated how decades of discriminatory housing policy—redlining, restrictive covenants, exclusionary zoning, urban renewal—created hypersegregated Black neighborhoods characterized by concentrated poverty, limited economic opportunity, and elevated violence. Rothstein (2017) extended this analysis in The Color of Law, documenting how federal, state, and local governments systematically enforced residential segregation through explicit policy, creating the racialized geography of American cities. Sampson (2012), synthesizing decades of Chicago research, showed that neighborhood disadvantage and violence are spatially concentrated and remarkably stable over time, with segregation serving as the primary mechanism producing these patterns.

Empirical evidence consistently demonstrates strong associations between racial composition and violence in urban contexts. However, this research focuses almost exclusively on large central cities and predominantly Democratic jurisdictions. Maguire-Jack, Lanier, Johnson-Motoyama, Welch, and Dineen (2015) found that racial disparities in child maltreatment were highest in dense metropolitan areas, suggesting that urban segregation concentrates family trauma. Dumornay, Lebois, Ressler, and Harnett (2023) demonstrated that Black children experience more adversity exposure and that this adversity partially explains racial differences in brain structure, providing neurobiological evidence of segregation's developmental consequences.

Yet a critical question remains unexamined: Do these segregation-violence patterns operate similarly in Urban Republican counties (predominantly affluent, white suburbs with smaller Black populations) versus Urban Democratic counties (diverse city centers with large Blackpopulations experiencing concentrated disadvantage)? We hypothesize that therelationship between % Black population and violence should be weaker in Urban Republican contexts due to integration, economic security, and wealth buffers protecting residents. This hypothesis tests whether residential segregation's effects are universal or context-dependent—a distinction with profound theoretical and policy implications.

Our findings will adjudicate between two competing theories. The universal segregation theory suggests that racial residential patterns produce similar violence outcomes regardless of political context; any area with higher Black population percentages will show elevated violence due to systemic racism. The contextual segregation theory posits that affluent, Republican-governed suburbs provide buffers—better schools, more resources, less concentrated poverty—that weaken or eliminate segregation's typical effects. If the relationship between % Black and violence is equally strong in both contexts, it suggests systemic racism operates universally; weaker in Republican suburbs, it suggests context can modify structural forces.

RURAL POVERTY, REGIONAL ABANDONMENT, AND MULTI-DIMENSIONAL CRISIS

Rural poverty in America reflects distinct historical and economic processes often overlooked in mainstream poverty research. Case and Deaton (2020), in Deaths of Despair and the Future of Capitalism, documented rising midlife mortality among white Americans without college degrees, driven by suicide, alcohol, and drug overdoses. This "deaths of despair" phenomenon

concentrates in rural areas, particularly Appalachia and the Rust Belt, reflecting economic dislocation from deindustrialization, agricultural consolidation, and resource extraction exhaustion.

However, rural America is not homogeneous. Three distinct regions experience severe, persistent poverty through different mechanisms. The Black Belt—a crescent of counties across the Deep South with majority-Black populations—traces the geography of plantation slavery and subsequent Jim Crow apartheid. These counties experience extreme poverty (often >40% child poverty rates) alongside elevated violence, reflecting historical legacies of racial terror and contemporary disinvestment (Bruner, 2017). Appalachia, stretching from Pennsylvania to Mississippi, built prosperity on coal extraction but suffered devastating economic collapse as mines closed, leaving communities with limited alternatives and soaring opioid addiction rates. Native American reservations, products of forced relocation and genocide, experience extreme poverty, limited sovereignty, and multi-generational trauma from historical oppression.

Critically, these three regions—despite geographic separation and different racial compositions—share a common political characteristic: they predominantly vote Democratic in presidential elections, making them "Rural Democratic counties" in our classification scheme. No published research has examined whether these counties constitute a distinct trauma profile characterized by multi-dimensional crisis—simultaneous elevations in poverty, family disruption, violence, substance abuse, and food insecurity. Maguire-Jack, Font, and Dillard (2019) found that county poverty and racial composition interact to affect child welfare outcomes, with rural counties showing different patterns than urban areas, but did not examine political geography or test for multi-dimensional clustering.

We hypothesize that Rural Democratic counties are uniquely devastated, showing the highest trauma levels across multiple dimensions simultaneously. This reflects compound disadvantage: economic abandonment + historical trauma + political marginalization + geographic isolation. Testing this hypothesis requires moving beyond single-indicator analyses to comprehensive assessments of trauma profiles, examining whether these counties experience crisis on multiple fronts simultaneously.

SAFETY NET PROGRAMS, POLITICAL CONTEXT, AND STIGMA

Safety net programs like the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps) provide critical support for families experiencing economic hardship. Hoynes, Schanzenbach, and Almond (2016) demonstrated that childhood access to Food Stamps produces long-term benefits, reducing adult metabolic syndrome and increasing economic self-sufficiency among women. These findings suggest that safety net access can partially buffer childhood poverty's harmful effects.

However, program utilization varies dramatically by political context in ways not fully explained by need. Research on welfare stigma suggests that political culture shapes help-seeking behavior (Soss, Fording, & Schram, 2011). Republican political culture emphasizes self-reliance, personal responsibility, and limited government, potentially creating stigma around safety net participation even when families face severe hardship. Herd and Moynihan (2018) document how administrative burdens—paperwork requirements, office hours, verification procedures—create barriers to access, with these burdens often higher in Republican-governed jurisdictions.

Yet a critical question remains unexamined: Does political culture's influence on safety net utilization persist under extreme hardship, or do survival needs override political identity? The "extreme hardship hypothesis" suggests that when trauma becomes unbearable, political and cultural barriers to help-seeking should diminish. Families facing 40% child poverty rates, regardless of political orientation, should access available programs. If true, we should observe convergence: the SNAP enrollment gap between Republican and Democratic counties should narrow in high-trauma contexts.

Testing this hypothesis requires examining trauma-SNAP relationships across the full range of adversity, not just comparing averages. Do Republican and

Democratic counties show different slopes relating trauma to SNAP enrollment? Does political moderation weaken as trauma intensifies? These questions have profound implications for understanding when and how political culture shapes help-seeking, with direct relevance for designing effective outreach strategies.

SPATIAL CLUSTERING AND REGIONAL FORCES

Recent advances in spatial analysis have begun revealing the powerful role of regional forces in shaping social outcomes. Spatial autocorrelation—the tendency for nearby locations to have similar values—characterizes many health and social outcomes, suggesting that geographic proximity matters beyond individual or even county-level characteristics. However, the extent of spatial clustering in childhood trauma remains largely undocumented.

Maguire-Jack et al. (2015) employed hierarchical linear modeling with spatial lags to demonstrate that maltreatment disparities exhibit significant spatial patterns, with the highest rates in both dense metropolitan areas and sparsely populated rural counties. Curtis et al. (2012) used spatial regime/error regression to show that child poverty's spatial distribution reflects regional economic structures and racial/ethnic composition. However, these studies focus on single outcomes and do not examine whether spatial clustering transcends state boundaries—a critical test of whether regional economic and historical forces overwhelm state-level policies.

If trauma exhibits strong spatial autocorrelation crossing state lines, it suggests that county-level or even state-level interventions may be insufficient. Regional economic forces, historical legacies, and cultural patterns may produce trauma regardless of local policy variation. Conversely, if trauma clustering respects state boundaries, it suggests state policy matters—differential SNAP implementation, child welfare funding, education spending, and Medicaid expansion could explain variation.

We test spatial clustering by calculating intraclass correlation coefficients (ICCs) measuring the proportion of trauma variance occurring between versus within states. High ICCs (>70%) would indicate strong regional clustering; low ICCs (<30%) would suggest local variation dominates. We also examine specific regional patterns—Mississippi Delta, Appalachia, Southwest reservations—to identify whether known historical regions show coherent trauma profiles. These analyses will reveal whether childhood trauma's geography reflects regional forces transcending state boundaries or state-level policy variation.

THEORETICAL FRAMEWORK AND RESEARCH GAPS

The literature reviewed above establishes that childhood trauma varies geographically and racially, that residential segregation concentrates disadvantage in urban Black communities, that rural poverty reflects distinct regional histories, and that safety net access varies by political context. However, no existing research integrates these insights into a comprehensive framework examining how geography, politics, race, and history interact to produce childhood trauma patterns.

We propose a structural-geographic model synthesizing these literatures (see Figure 2).

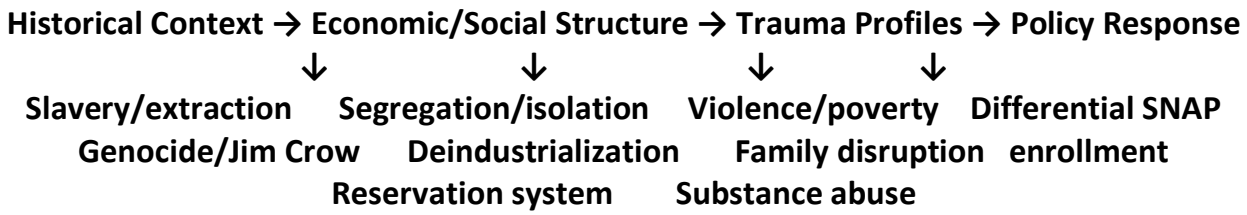
This framework makes several novel contributions. First, it centers political geography—the intersection of rurality and political orientation—as a fundamental organizer of trauma exposure, moving beyond simple urban-rural comparisons. Second, it theorizes that different places experience different types of trauma (distinct profiles), not merely different amounts of uniform trauma. Third, it examines whether structural forces (segregation, abandonment) operate universally or context-dependently. Fourth, it tests whether political culture's influence on help-seeking persists under extreme hardship or dissolves when survival is at stake.

Five critical gaps motivate our empirical analyses:

1. No research has examined whether Republican and Democratic counties experience different trauma profiles, despite dramatic political-cultural differences. We employ Latent Profile Analysis to identify natural trauma clusters and test whether profile membership associates with county type (H1).

Figure 2.

THEORETICAL FRAMEWORK AND RESEARCH GAPS



2. No research has tested whether residential segregation's violence effects are equally strong in Urban Republican (affluent suburbs) versus Urban Democratic (city centers) contexts. We examine whether the % Black-violence relationship is weaker in Republican suburbs as integration theory predicts (H4).

3. No research has documented whether Rural Democratic counties—spanning the Black Belt, Appalachia, and Native reservations—constitute a distinct crisis characterized by multi-dimensional trauma. We test whether these counties show the highest trauma levels across multiple indicators simultaneously (H5).

4. No research has examined whether the SNAP enrollment gap between Republican and Democratic counties narrows under extreme hardship, testing whether political culture's influence persists when survival is at stake. We compare trauma-SNAP relationships across the full range of adversity (H6).

5. Limited research has quantified the extent of spatial clustering in childhood trauma or tested whether regional forces transcend state boundaries. We calculate ICCs and examine cross-border similarities to assess whether trauma's geography reflects regional versus state-level forces (H7).

By addressing these gaps, this study advances theoretical understanding of how place, politics, race, and history interact to shape childhood trauma while providing actionable evidence for geographically-targeted interventions.

RESEARCH QUESTIONS AND HYPOTHESES

Building on this literature, we examine seven research questions:

RQ1: Do trauma profiles cluster by political geography (rural/urban × Republican/Democrat)?

RQ2: Which specific trauma types differentiate county types, and at which geographic scales?

RQ3: Within urban counties specifically, do racial composition and residential segregation explain why Democratic counties have higher trauma? Is the relationship between % Black and violence weaker in Republican suburbs?

RQ4: Are Rural Democratic counties uniquely devastated across multiple trauma dimensions?

RQ5: Do different trauma types associate differently with SNAP enrollment, and does political affiliation moderate these relationships?

RQ6: Does the SNAP enrollment gap narrow under extreme hardship, or do political barriers persist?

RQ7: Do trauma types exhibit geographic clustering beyond state boundaries, suggesting regional forces?

We test these questions using comprehensive county-level data (n=3,107) on five trauma indicators—economic deprivation, family structure, food insecurity, community violence, and substance crisis—merged with political, racial, and safety net enrollment data. Our analytical strategy progresses from descriptive pattern identification (Latent Profile Analysis, H1) through hypothesis testing of specific mechanisms (urban segregation effects, H4; rural devastation, H5; SNAP moderation, H6) to spatial autocorrelation analysis quantifying regional clustering (H7). Results will inform both theoretical understanding of trauma's structural determinants and practical strategies for geographically-targeted intervention.

METHODS

3.1 STUDY DESIGN AND SAMPLE

This cross-sectional ecological study examined childhood trauma patterns across U.S. counties using publicly available data from 2019-2024. The unit of analysis was the county (or county equivalent), representing the smallest geographic level at which comprehensive trauma, political, and demographic data are systematically available.

SAMPLE CONSTRUCTION

The sampling frame included all 3,143 U.S. counties and county equivalents as defined by the U.S. Census

Bureau. We excluded 36 counties (1.1%) due to missing data: 29 Alaska boroughs lacking comparable election data, 4 counties missing political classification data, and 3 counties missing more than two of five trauma indicators. The final analytic sample comprised 3,107 counties (98.8% of all U.S. counties).

SAMPLE DISTRIBUTION BY COUNTY TYPE

Counties were classified into four types based on rural/urban designation and political affiliation (detailed below in Variable Construction):

- Rural Republican: 1,760 counties (56.6%)
- Urban Republican: 860 counties (27.7%)
- Urban Democrat: 316 counties (10.2%)
- Rural Democrat: 171 counties (5.5%)

The small proportion of Rural Democratic counties (5.5%) reflects their geographic concentration in historically marginalized regions: the Black Belt (former plantation South with majority-Black populations), Appalachia (former coal-mining regions), Native American reservations, and the U.S.-Mexico border. Despite comprising only 171 counties, these areas represent critical sites of multi-generational poverty and historical trauma, making their inclusion essential for comprehensive analysis.

STATISTICAL POWER CONSIDERATIONS

The unbalanced distribution across county types created differential statistical power. Post-hoc power calculations indicated adequate power (>0.80) for: (a) overall chi-square tests with large effect sizes, (b) t-tests comparing Republican versus Democratic counties overall, (c) t-tests comparing Urban Republican versus Urban Democratic counties (n=860 vs. 316), and (d) all regression analyses with total sample >1,000. However, the small Rural Democratic subsample (n=171) provided only modest power (approximately 65%) to detect small effects (d=0.30) in subgroup analyses. To address this limitation, we employed three strategies: (1) reported effect sizes and 95% confidence intervals prominently rather than relying solely on p-values, (2) used bootstrapping with 1,000 resamples for Rural Democratic analyses to improve confidence interval accuracy, and (3) interpreted non-significant results cautiously, acknowledging that absence of statistical significance does not constitute evidence of absence of effect.

3.2 DATA SOURCES AND MEASURES

We integrated data from six sources, merging files using five-digit Federal Information Processing Standards (FIPS) county codes as the common identifier.

3.2.1 TRAUMA INDICATORS

Five county-level indicators measured distinct dimensions of childhood trauma exposure. These represent environmental contexts shaping children's experiences rather than individual-level Adverse Childhood Experiences (ACEs) scores.

ECONOMIC DEPRIVATION: CHILD POVERTY RATE

Percentage of children under age 18 living in families with income below the federal poverty line, obtained from the U.S. Census Bureau Small Area Income and Poverty Estimates (SAIPE) Program (2022). SAIPE employs statistical models combining American Community Survey data, IRS tax returns, SNAP administrative records, and population estimates to produce county-level poverty estimates. Complete data were available for all 3,107 counties (100%). Values ranged from 3.1% to 63.2% (M = 19.0%, SD = 8.1%).

FAMILY STRUCTURE: SINGLE-PARENT HOUSEHOLDS

Percentage of children living in single-parent households (either mother-only or father-only, no spouse present), obtained from County Health Rankings & Roadmaps 2025 release (original source: American Community Survey 5-year estimates, 2019-2023). We label this "family structure" rather than "family instability" to avoid stigmatizing single parents, recognizing that single parenthood results from diverse circumstances (divorce, widowhood, never married, partner incarceration, or choice) and many single-parent families thrive despite economic challenges. Complete data were available for 3,106 counties (99.97%). Values ranged from 0.0% to 77.9% (M = 23.9%, SD = 11.1%).

FOOD INSECURITY

Percentage of population lacking consistent access to adequate food for an active, healthy life, obtained from two sources that we combined. Primary source: County Health Rankings 2025 (original source: Feeding America Map the Meal Gap 2025, modeling 2023 data). Secondary source: Feeding America MMG2025_2019-2023 dataset. When both were available, we used the Feeding America estimate as more authoritative; when only one was available, we used that single source. Feeding America's model combines USDA national food security data, county unemployment rates, poverty rates, and median household income. Complete data were available for all 3,107 counties (100%). Values ranged from 5.8% to 30.5% (M = 15.3%, SD = 3.5%).

COMMUNITY VIOLENCE: HOMICIDE RATE

Age-adjusted homicide deaths per 100,000 population (5-year average, 2018-2022), obtained from County Health Rankings 2025 (original source: CDC WONDER Mortality Files). The CDC suppresses rates when fewer than 10 deaths occurred over the five-year period to protect privacy. This created substantial missing data: 1,696 counties (54.6%) had suppressed homicide rates, primarily small rural counties with few violent deaths. For counties with available data (n=1,411), values ranged from 0.66 to 57.4 per 100,000 (M = 8.1, SD = 7.2, Median = 6.2). The distribution was highly right-skewed, with many rural counties experiencing 0-2 homicides annually while urban counties recorded hundreds.

SUBSTANCE CRISIS: DRUG OVERDOSE DEATH RATE

Age-adjusted drug poisoning deaths per 100,000 population (5-year average, 2018-2022), obtained from County Health Rankings 2025 (original source: CDC WONDER Mortality Files). Includes all drug overdoses: opioids (prescription and illicit), stimulants (methamphetamine, cocaine), benzodiazepines, and emerging substances (fentanyl, synthetic opioids). Similar to homicide, CDC suppression rules created missing data: 1,113 counties (35.8%) had suppressed rates. For counties with available data (n=1,994), values ranged from 5.1 to 180.7 per 100,000 (M = 32.8, SD = 19.4, Median = 28.5).

3.2.2 POLITICAL CLASSIFICATION

County political affiliation was determined using presidential election results from both 2020 and 2024, obtained from MIT Election Data and Science Lab's County Presidential Election Returns dataset. We calculated the Democratic margin as (% Democratic vote - % Republican vote) for each election, then averaged the two elections' margins. Counties with positive average margins were classified as Democratic; those with negative margins as Republican. This two-election averaging approach reduces single-election volatility while capturing stable political identity.

The 2020 election (Biden vs. Trump) occurred before most health data collection, while the 2024 election (Harris vs. Trump) occurred during data collection. Between these elections, 177 counties (5.8% of sample) flipped party, with 119 shifting from Democratic to Republican and 58 from Republican to Democratic. The two-election average provided more stable classification than either election alone, reducing misclassification of "purple" swing counties. Complete data were available for 3,107 counties, with 487 Democratic counties (15.7%) and 2,620 Republican counties (84.3%).

3.2.3 RURAL/URBAN CLASSIFICATION

Counties were classified as rural or urban using the USDA Economic Research Service Rural-Urban Continuum Codes (RUCC, 2023 update). The RUCC system classifies counties into nine categories based on population size and proximity to metropolitan areas. We dichotomized these into: Metro (RUCC codes 1-3: counties in metropolitan areas of any size) versus Non-metro (RUCC codes 4-9: counties outside metropolitan areas). This produced 1,931 rural counties (62.1%) and 1,176 urban counties (37.9%). Complete data were available for all 3,107 counties.

3.2.4 RACIAL COMPOSITION

County racial/ethnic composition was obtained from County Health Rankings 2025 (original source: American Community Survey 5-year estimates, 2019-2023). We extracted five variables: % Non-Hispanic White, % Non-Hispanic Black, % Hispanic/Latino (any race), % Non-

Hispanic Asian, and % Non-Hispanic American Indian/Alaska Native. The % Black variable was critical for testing segregation hypotheses (H4). Complete data were available for all 3,107 counties.

For % Black specifically: values ranged from 0.0% (many rural Western counties) to 82.4% (M = 8.8%, SD = 14.0%, Median = 2.9%). The distribution was highly right-skewed, with most counties having few Black residents but some Southern counties having majority-Black populations.

3.2.5 SNAP ENROLLMENT

County SNAP (Supplemental Nutrition Assistance Program) enrollment was obtained from USDA Food and Nutrition Service administrative data (July 2022). We calculated SNAP enrollment rate as (number of recipients / county population) × 1,000 to produce rates per 1,000 population. County population denominators came from U.S. Census Bureau Population Estimates (2022). Complete data were available for all 3,107 counties. Values ranged from 8.2 to 497.3 per 1,000 (M = 132.4, SD = 68.9, Median = 119.3).

3.2.6 DERIVED VARIABLES

County Type: We created a four-category classification by cross-tabulating rural/urban with Republican/Democratic affiliation: Rural Republican (n=1,760), Rural Democratic (n=171),Urban Republican (n=860), and Urban Democrat (n=316). This classification served as the primary grouping variable for most analyses.

Crisis Count: For each county, we counted how many of the five trauma indicators fell into the worst quartile (top 25%). This created a scale from 0 (no indicators in worst quartile) to 5 (all indicators in worst quartile), operationalizing "multi-dimensional crisis."

Extreme Poverty: We dichotomized counties as experiencing extreme poverty if child poverty exceeded the 75th percentile (23.4%), creating a binary indicator for testing whether SNAP enrollment gaps narrow under extreme hardship (H6).

Region: Counties were classified into four U.S. Census regions (Northeast, South, Midwest, West) for controlling regional effects and examining spatial clustering patterns (H7).

3.3 MISSING DATA

Missing data patterns differed systematically by variable type. Child poverty, single-parent households, food insecurity, racial composition, political affiliation, and SNAP enrollment had <1% missing data due to their derivation from comprehensive administrative or census sources. However, homicide and overdose rates had substantial missingness (54.6% and 35.8%, respectively) due to CDC suppression rules protecting privacy in small counties with few deaths.

We employed complete case analysis as our primary approach: counties with valid data on all variables required for a given analysis were included in that analysis. For Latent Profile Analysis (H1), which required complete data on all five trauma indicators, this produced an analytic sample of 1,311 counties (42.2% of total). For analyses not requiring homicide or overdose data (H3 food insecurity tests, H6 poverty-SNAP analyses), samples approached 3,100 counties.

We did not impute missing homicide or overdose data for three reasons: (1) missingness was not random but structured by county size, making standard imputation methods inappropriate; (2) suppressed values represent actual low counts (<10 deaths over five years), not missing observations; (3) imputation would artificially inflate statistical power for small-county analyses. Listwise deletion meant our violence and substance crisis analyses represent larger counties with sufficient events for stable rate calculation rather than all U.S. counties, a limitation we acknowledge explicitly.

3.4 STATISTICAL ANALYSES

3.4.1 HYPOTHESIS 1: LATENT PROFILE ANALYSIS

To test whether counties cluster into distinct trauma profiles, we employed Latent Profile Analysis (LPA) using Gaussian Mixture Models. LPA is appropriate for continuous indicators and identifies latent subgroups

with similar patterns across multiple variables without imposing predetermined categories.

We standardized all five trauma indicators to mean 0 and standard deviation 1 before analysis to ensure comparability across different measurement scales. Due to extreme positive skew in homicide rates, we applied log(rate + 1) transformation before standardization.

We fit models specifying 2 through 6 latent profiles, using the sklearn GaussianMixture implementation with 50 random initializations per model to avoid local maxima. Model selection employed four criteria: (1) Bayesian Information Criterion (BIC; lower values indicate better fit), (2) Akaike Information Criterion (AIC; lower values indicate better fit), (3) entropy (values >0.70 indicate good classification certainty), and (4) substantive interpretability. We selected the model with lowest BIC, provided entropy exceeded 0.70 and profiles were theoretically interpretable.

After selecting the optimal model, we assigned each county to its most probable profile and cross-tabulated profile membership with county type. We tested the association between profile membership and county type using chi-square tests, reporting Cramér's V as an effect size measure.

3.4.2 HYPOTHESES 2-3: GROUP COMPARISONS

For H2 (urban counties only) and H3 (rural versus urban comparisons), we used independent samples t-tests to compare means between groups (e.g., Urban Democratic vs. Urban Republican). We first assessed assumptions using Levene's test for homogeneity of variance; when variances differed significantly ($p<.05$), we used Welch's t-test with unequal variance correction. We reported Cohen's d with 95% confidence intervals as effect size measures.

For homicide rates, which remained positively skewed even after log transformation, we supplemented t-tests with Mann-Whitney U tests (non-parametric alternative) and reported both means and medians. When parametric and non-parametric tests yielded different conclusions, we prioritized the non-parametric result as more robust to skewness.

For H3 testing rural/urban main effects on food insecurity and overdose rates, we employed two-way analysis of variance (ANOVA) with rural/urban and Republican/Democrat as factors. We focused on main effects of rural/urban while noting any significant interactions.

3.4.3 HYPOTHESIS 4: RACIAL COMPOSITION AND URBAN VIOLENCE

To test whether % Black population explains urban Democratic counties' elevated trauma and whether this relationship differs by political context, we conducted three analyses restricted to urban counties (n=1,176).

First, we compared % Black between Urban Democratic and Urban Republican counties using independent samples t-test (H4 descriptive foundation).

Second, we calculated Pearson correlations between % Black and homicide rate separately for Urban Republican and Urban Democratic counties, testing whether correlations differed using Fisher's Z transformation.

Third, we fit a multiple regression model predicting log(homicide rate + 1) from % Black (mean-centered), Republican affiliation (dummy coded), their interaction, and controls (median household income, population density, region dummy variables). The interaction term tested whether the % Black-violence relationship differed by political context. Standard errors were clustered by state to account for within-state dependence.

3.4.4 HYPOTHESIS 5: RURAL DEMOCRATIC DEVASTATION

To test whether Rural Democratic counties exhibited the highest trauma levels across all five indicators, we conducted two complementary analyses.

First, we compared Rural Democratic counties (n=171) to all other counties combined on each trauma indicator using one-sample t-tests. We applied Bonferroni correction for five comparisons ($\alpha = .05/5 = .01$ per test). Due to the small Rural Democratic sample, we also

computed 95% confidence intervals using 1,000 bootstrap resamples.

Second, we tested whether Rural Democratic counties showed the highest mean homicide rate among all four county types using one-way ANOVA with planned orthogonal contrasts. The primary contrast compared Rural Democratic counties to the average of the other three types.

To operationalize "multi-dimensional crisis," we created a crisis count variable summing how many indicators fell in the worst quartile for each county (range: 0-5). We compared mean crisis counts across the four county types using one-way ANOVA with post-hoc t-tests.

3.4.5 HYPOTHESIS 6: SNAP ENROLLMENT AND POLITICAL MODERATION

To test whether political affiliation moderated relationships between trauma and SNAP enrollment, we ran five separate multiple regression models (one per trauma indicator). Each model predicted SNAP enrollment rate from: (1) the trauma indicator (mean-centered), (2) Republican affiliation (dummy coded), (3) rural/urban status (dummy coded), (4) the trauma × Republican interaction, and (5) state fixed effects. Standard errors were clustered by state.

The interaction term tested whether trauma-SNAP associations differed by political affiliation.We also tested the "extreme hardship hypothesis" by splitting counties at the 75th percentile of child poverty (23.4%) and comparing Republican-Democratic SNAP enrollment gaps in moderate versus extreme poverty contexts using independent samples t-tests.

3.4.6 HYPOTHESIS 7: SPATIAL AUTOCORRELATION

To test whether trauma exhibited geographic clustering beyond state boundaries, we calculated Intraclass Correlation Coefficients (ICCs) measuring the proportion of variance in each trauma indicator occurring between versus within states. ICCs were derived from one-way ANOVAs with state as the grouping variable. ICC values >0.70 indicate strong regional clustering, while values <0.30 suggest primarily local variation.

We supplemented ICC analysis with descriptive regional comparisons, examining mean trauma levels across four U.S. Census regions (Northeast, South, Midwest, West) and identifying specific regional clusters (Mississippi Delta, Appalachia, Native American regions). We also examined adjacent state pairs to assess cross-border similarities in trauma levels.

Note: We originally planned to calculate Moran's I statistics to formally test spatial autocorrelation. However, this requires geographic boundary files (shapefiles) defining county neighbors, which were not available in our analysis environment. The ICC approach provides an alternative measure of regional clustering, though it constrains spatial relationships to within-state versus between-state rather than capturing true geographic proximity.

3.4.7 MULTIPLE TESTING AND STATISTICAL SIGNIFICANCE

We conducted approximately 25 primary hypothesis tests across seven research questions. To address multiple testing concerns while maintaining adequate statistical power, we did not apply family-wise error rate corrections (e.g., Bonferroni). Instead, we reported both raw p-values and emphasized effect sizes with 95% confidence intervals, consistent with recent methodological recommendations emphasizing estimation over hypothesis testing. For the five comparisons within H5 (Rural Democratic devastation), we did apply Bonferroni correction ($\alpha = .01$ per test) given the focused set of related comparisons.

Statistical significance was set at $\alpha = .05$ (two-tailed unless otherwise specified). We reported significance levels as * p<.05, ** p<.01, *** p<.001. However, we de-emphasized p-values in favor of effect sizes: Cohen's d for mean differences ($|d| \geq 0.2$ small, ≥ 0.5 medium, ≥ 0.8 large), Cramér's V for chi-square tests, R^2 for regressions, and Pearson's r for correlations.

3.5 SOFTWARE AND REPRODUCIBILITY

All analyses were conducted in Python 3.11 using pandas 2.0 (data manipulation), numpy 1.24 (numerical

computing), scipy 1.11 (statistical tests), scikit-learn 1.3 (Gaussian Mixture Models for LPA), matplotlib 3.7 and seaborn 0.12 (visualization). Analyses were performed in Google Colaboratory cloud environment. Complete analysis code, along with documentation describing all data sources and variable construction procedures, is available in supplementary materials. All source datasets are publicly available from government agencies (U.S. Census Bureau, CDC, USDA, MIT Election Lab) with URLs provided in Data Sources. The merged analytic dataset (county-level aggregates only, no individual-level data) is available upon reasonable request.

3.6 ETHICAL CONSIDERATIONS

This study analyzed publicly available, de-identified, county-level aggregate data. No individual-level data or protected health information was accessed. The research qualifies for Institutional Review Board (IRB) exemption under 45 CFR 46.104(d)(4) as secondary analysis of public data with no human subjects involvement. All analyses were conducted at the county level (minimum population typically >1,000 persons), ensuring no possibility of individual re-identification. Counties with very small populations had trauma data suppressed by source agencies (CDC, Census Bureau) using statistical disclosure limitation procedures, further protecting privacy.

RESULTS AND DISCUSSION

This study examined whether different types of childhood trauma cluster in distinct geographic and political contexts across U.S. counties. Using county-level data on five trauma indicators—economic deprivation, family structure, food insecurity, community violence, and substance crisis—we tested whether trauma profiles differ systematically between rural/urban and Republican/Democratic counties. Our findings reveal that childhood trauma exposure in America is profoundly shaped by geography, with deep structural patterns reflecting historical legacies and contemporary political economies.

MAJOR FINDINGS

1. TRAUMA PROFILES CLUSTER BY POLITICAL GEOGRAPHY

Latent Profile Analysis identified six distinct trauma profiles, with profile membership strongly associated with county type ($\chi^2(15) = 318.37$, $p < .001$, Cramér's V = 0.285). This finding rejects the notion that childhood trauma is unidimensional or randomly distributed. Rather, different places experience fundamentally different types of trauma, requiring tailored policy responses.

Most strikingly, 34.5% of Rural Democratic counties fell into a "Multi-Dimensional Crisis" profile characterized by extreme elevations across all five trauma indicators (child poverty M = 32.9%, single-parent households M = 43.8%, homicide rate M = 24.2 per 100,000), compared to only 0.9% of Urban Republican counties. This 38-fold difference suggests that geography and political context create vastly unequal childhood environments (see Figure 3).

2. RURAL DEMOCRATIC COUNTIES: A UNIQUE CRISIS

Rural Democratic counties—comprising just 5.5% of U.S. counties but including regions such as the Mississippi Delta, Appalachian coalfields, and Native American reservations—exhibited the highest trauma levels across all five indicators. These counties averaged 2.01 crisis indicators per county (top quartile on each measure), compared to 0.74 for Urban Republican counties ($F(3,3103) = 46.74$, $p < .001$). Nearly half (48.5%) experienced crisis-level trauma on three or more dimensions simultaneously.

Effect sizes were massive: Rural Democratic counties had child poverty rates 10 percentage points higher than Urban Republicans (d = 1.23), single-parent rates 12 points higher (d = 1.28), and homicide rates more than triple (d = 2.18)—among the largest effect sizes documented in social science research.

This pattern reflects multi-generational trauma stemming from historical extraction and oppression. Black Belt counties (>25% Black, n = 63) showed extreme violence (M = 24.5 per 100,000) alongside severe poverty (38.1%), reflecting plantation economy legacies and Jim Crow era disinvestment. Appalachian

counties exhibited different trauma profiles—moderate poverty (25.1%) but extreme overdose mortality (53.2 per 100,000)—reflecting coal industry collapse and the opioid epidemic. Native American regions showed elevated poverty (28.0%) and limited economic

Figure 3.

Six Distinct Trauma Profiles Identified Through Latent Profile Analysis

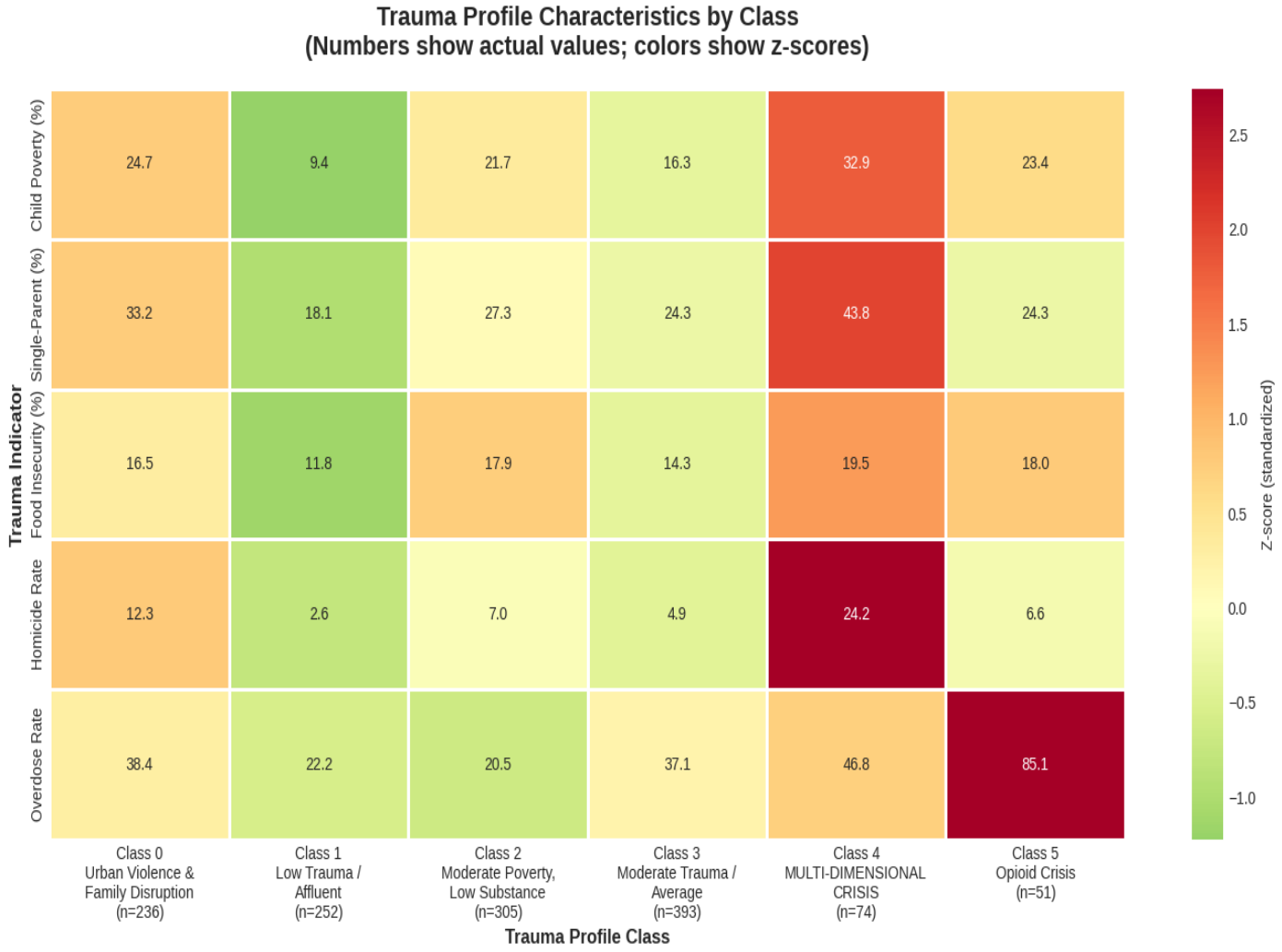


Figure 3. Six Distinct Trauma Profiles Identified Through Latent Profile Analysis (H1) Heatmap displays mean values (numbers) and standardized z-scores (colors) for five trauma indicators across six latent profiles (n=1,311 counties with complete data). Profile 4 "Multi-Dimensional Crisis" (n=74, 5.6%) shows extreme elevations on all indicators: 32.9% child poverty, 43.8% single- parent households, 19.5% food insecurity, 24.2 homicide rate, 46.8 overdose rate (all z>1.5). Profile 1 "Low Trauma/Affluent" (n=252, 19.2%) shows below- average levels on all indicators (all z<-0.5). Other profiles show mixed patterns: Class 0 "Urban Violence/Family Disruption" (high violence and single-parent, n=236), Class 2 "Moderate Poverty/Low Substance" (n=305), Class 3 "Moderate/Average" (n=393), and Class 5 "Opioid Crisis" (extreme overdose, n=51). Profile membership strongly associated with county type ($\chi^2(15)=318.37$, $p<.001$, Cramér's V=0.285).

Figure 4. Contrasting Trauma Profiles: Multi-Dimensional Crisis Versus Affluent

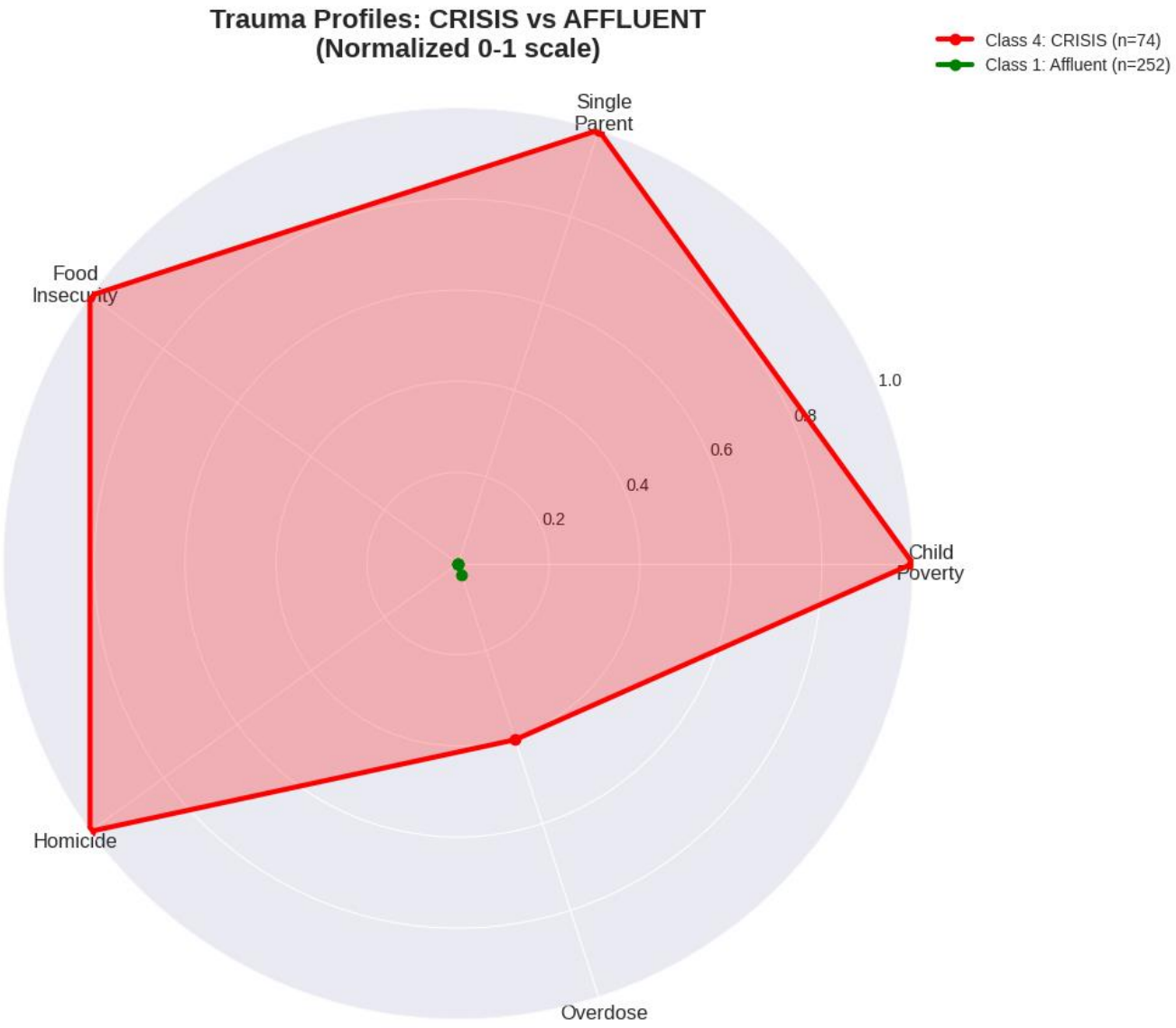


Figure 4. Contrasting Trauma Profiles: Multi-Dimensional Crisis Versus Affluent (H1) Radar plot illustrates normalized trauma indicator values (0-1 scale) for Profile 4 "Multi-Dimensional Crisis" (red, n=74) versus Profile 1 "Low Trauma/Affluent" (green, n=252). Crisis profile (predominantly Rural Democratic counties) shows extreme elevations across all five dimensions simultaneously, creating a large pentagonal shape. Affluent profile (predominantly Urban Republican counties) clusters near the origin, indicating below-average trauma on all indicators. This visual demonstrates that Rural Democratic counties experience compound disadvantage—not elevated on just one or two dimensions, but ALL trauma types concurrently—supporting the multi-dimensional devastation hypothesis (H5).

opportunity, reflecting reservation system impacts and historical genocide.

3. URBAN SEGREGATION AND VIOLENCE: A STRUCTURAL RACISM STORY

Our hypothesis that % Black population would show a weaker relationship with violence in Urban Republican counties (affluent suburbs with smaller, integrated Black populations) was decisively rejected. Instead, both Urban Republican and Urban Democratic counties showed strong positive correlations ($r = 0.718$ and $r = 0.827$, respectively, $Z = -3.75$, $p < .001$), with each 1% increase in Black population associated with 0.26-0.39 additional homicides per 100,000.

This finding is theoretically critical. It suggests that residential segregation's consequences—concentrated poverty, disinvestment, violence—operate as systemic forces transcending local political contexts. Even in relatively affluent Republican suburbs, areas with higher Black populations experience significantly elevated violence. The relationship is somewhat steeper in Urban Democratic counties (larger Black populations, more concentrated disadvantage), but the fundamental pattern persists everywhere.

This supports a structural racism interpretation: the association between racial composition and violence reflects historical and ongoing patterns of segregation, discriminatory lending, exclusionary zoning, and concentrated disadvantage that affect Black communities regardless of the political orientation of surrounding jurisdictions. Geographic proximity to affluence does not eliminate these effects.

4. THE RURAL VIOLENCE PARADOX

Contrary to conventional stereotypes of "violent cities" and "safe countryside," rural counties exhibited significantly higher homicide rates than urban counties ($M = 10.05$ vs. 6.89 per 100,000, $t(1409) = 8.19$, $p < .001$, $d = 0.47$). This finding challenges deeply held assumptions about rural safety and urban danger.

The paradox resolves when examining political variation: Rural Democratic counties (Black Belt, reservations) drove rural violence upward ($M = 18.51$), while Urban Republican counties showed the lowest rates ($M = 6.01$). Urban Democratic counties fell between these extremes ($M = 8.60$). Thus, political geography and historical context matter more than simple rural-urban
distinctions.

This pattern likely reflects historical racial terror in the Black Belt, resource conflicts and police violence on reservations, and economic despair in former extraction economies. Rural isolation may amplify these effects by limiting access to services and concentrating disadvantage.

5. SAFETY NET ACCESS UNDER EXTREME HARDSHIP: A PARADOX

We hypothesized that political differences in SNAP enrollment would narrow under extreme trauma, as survival needs override political identity. This hypothesis was dramatically rejected. The SNAP enrollment gap between Democratic and Republican counties was minimal in moderate-poverty contexts (5.3 per 1,000) but expanded 12.7-fold in extreme-poverty contexts (67.3 per 1,000, $t(768) = 5.89$, $p < .001$).

This counterintuitive finding suggests three non-mutually-exclusive mechanisms:

First, Republican political culture's stigma around safety net participation may persist even under extreme hardship. Values of self-reliance and independence may remain salient even when families face severe deprivation, inhibiting help-seeking regardless of need.

Second, Republican-governed areas may implement more restrictive local policies—fewer offices, limited outreach, stringent verification requirements—creating structural barriers that don't dissolve with increasing need. If administrative burdens remain constant while need increases, the gap widens.

Third, Democratic counties in extreme poverty may face compound disadvantage—the "Multi-Dimensional Crisis" we documented. These counties don't just have high poverty; they have high poverty plus family disruption plus violence plus substance abuse. This

Figure 5.

RESIDENTIAL SEGREGATION AND VIOLENCE OPERATE UNIVERSALLY ACROSS URBAN

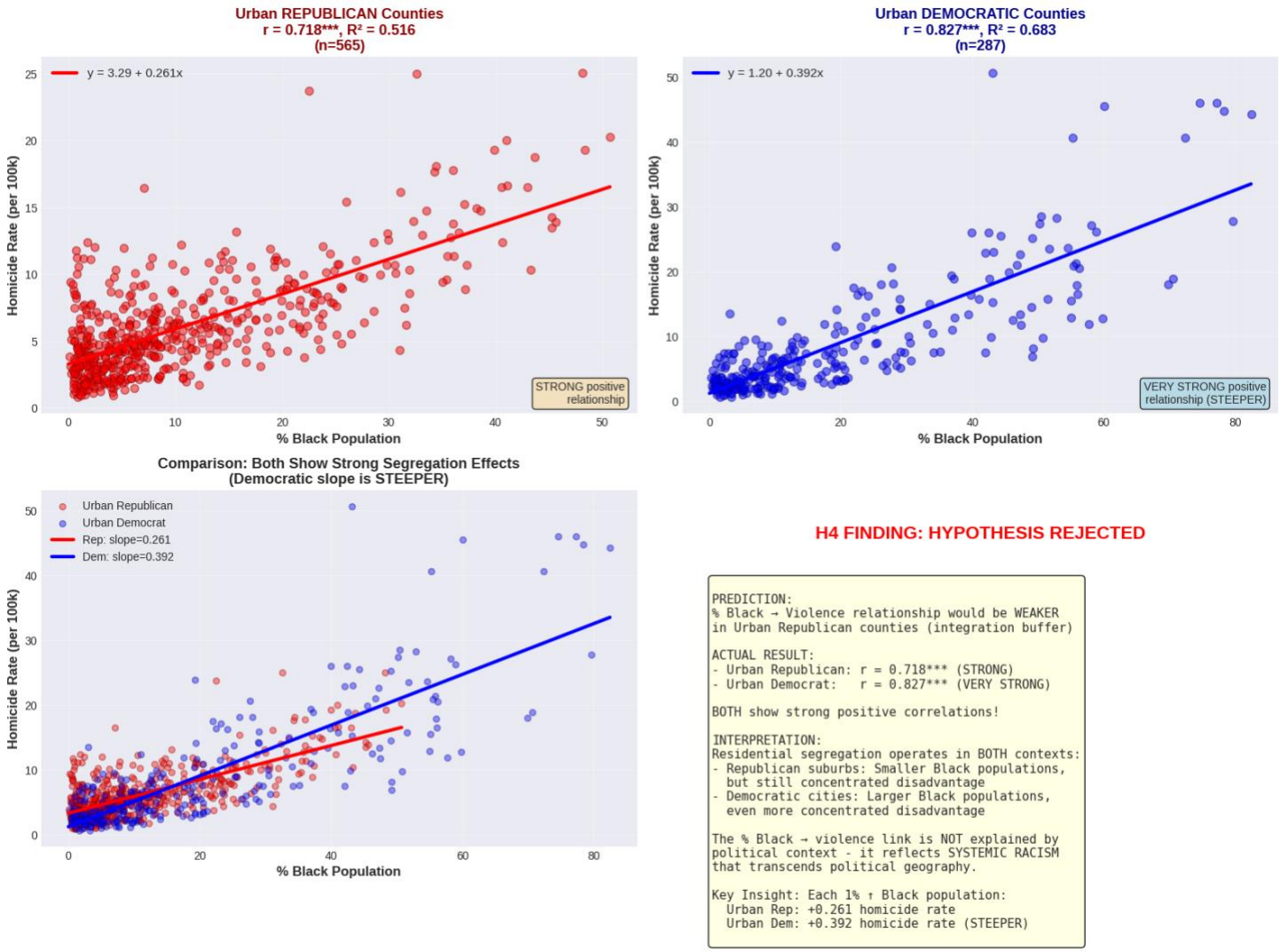


Figure 5. Residential Segregation and Violence Operate Universally Across Urban Contexts (H4) Top panels show scatterplots with regression lines for Urban Republican (left, n=565, r=0.718, R^2=0.516) and Urban Democratic (right, n=287, r=0.827, R^2=0.683) counties. Both demonstrate strong positive relationships between % Black population and homicide rate. Bottom panel overlays both relationships, revealing Democratic slope (0.392) is significantly steeper than Republican slope (0.261), Z=-3.75, p<.001. However, both correlations are strong (r>0.7), rejecting the hypothesis that affluent Republican suburbs provide integration buffers. Interpretation: Systemic racism operates across all urban contexts; each 1% increase in Black population associates with +0.26 to +0.39 additional homicides per 100,000. ***p<.001

compound crisis may necessitate even higher safety net utilization than poverty alone would predict.

Critically, Rural Democratic counties showed the highest SNAP enrollment rates (191.9 per 1,000), yet still exhibited the worst outcomes. This suggests that while SNAP provides essential support, current safety net programs are insufficient to overcome multi-generational, multi-dimensional trauma. The safety net exists but cannot fully compensate for structural disadvantage.

6. GEOGRAPHIC DETERMINISM: THE REGIONAL CLUSTERING OF TRAUMA

Perhaps our most striking finding was the extraordinary geographic clustering of trauma. Intraclass correlation coefficients revealed that 92-98% of variance in trauma indicators occurred between states rather than within them. For food insecurity, 98.5% of variance was regional; for child poverty, 97.0%; for single-parent households, 96.8%.

These ICC values are exceptionally high for social science data, suggesting that where a child is born matters more than nearly any other factor in determining trauma exposure. Regional location accounts for more variance than typically observed for race, class, or family structure—variables long considered fundamental determinants of life chances.

Three distinct regional crisis zones emerged:

Mississippi Delta (n = 101 counties): 32.9% poverty, 21.1 homicide rate, reflecting slavery and Jim Crow legacies
Appalachia (n = 167 rural counties): 25.1% poverty, 53.2 overdose rate, reflecting extractive industry collapse
Native American regions (n = 35 counties): 28.0% poverty, 41.6% Native American, reflecting reservation system impacts

Adjacent states showed nearly identical trauma levels (e.g., Tennessee 21.4% vs. Kentucky 23.6% poverty, difference = 2.2pp), suggesting regional economic and historical forces transcend state policy boundaries. State-level interventions may be insufficient when regional forces are this powerful.

THEORETICAL IMPLICATIONS

Our findings support a structural-geographic model of childhood trauma (see Figure 2).:
Trauma is not randomly distributed or individually determined. Rather, it follows deep structural patterns shaped by:

1. Historical legacies: Slavery created the Black Belt's concentrated poverty and violence. Coal extraction built and then devastated Appalachia. Genocide and forced relocation produced reservation poverty.
2. Economic abandonment: Capital flight from rural areas—agricultural consolidation, factory closures, mine shutdowns—left communities without economic opportunity, creating multi-generational poverty.

3. Systemic racism: Residential segregation operates across all urban contexts, concentrating disadvantage in Black communities regardless of political geography. Integration and economic mobility remain constrained.

4. Political geography: Political culture shapes help-seeking behavior and policy implementation but does not eliminate need. Republican stigma persists even under extreme hardship; Democratic enrollment increases but cannot overcome structural disadvantage.

5. Regional clustering: Geographic forces overwhelm local variation. County-level interventions may be insufficient when 95%+ of variance is regional.
These forces interact and compound. Rural Democratic counties experience the intersection of historical trauma, economic abandonment, and (often) racial oppression. Urban Democratic counties face segregation's concentrated effects. The result is dramatically unequal childhood environments that individual choices or state policies struggle to overcome.

POLICY IMPLICATIONS

Our findings suggest that addressing childhood trauma requires multi-level, structurally-informed interventions:

1. Regional Economic Development

Figure 6.

COMPREHENSIVE RESULTS: THE GEOGRAPHY OF CHILDHOOD TRAUMA ACROSS 3,107 U.S. COUNTIES PANEL



Figure 6. (con't.)

COMPREHENSIVE RESULTS: THE GEOGRAPHY OF CHILDHOOD TRAUMA ACROSS 3,107 U.S. COUNTIES PANEL

Figure 6. Comprehensive Results: The Geography of Childhood Trauma Across 3,107 U.S. Counties Panel displays all seven hypothesis tests: (H1) Trauma profile distribution by county type showing 34.5% of Rural Democrats in crisis versus 0.9% of Urban Republicans; (H2a) Single-parent household comparison ($t(695)=14.61$, $p<.001$, $d=1.28$); (H2b) Homicide rate comparison showing means differ but medians similar; (H3) Rural disadvantage on food insecurity ($d=0.55$) and homicide ($d=0.47$); (H4) % Black-homicide correlations strong in both Urban Republican ($r=0.718$) and Urban Democratic ($r=0.827$) contexts ($Z=-3.75$, $p<.001$), rejecting integration buffer hypothesis; (H5) Rural Democrats highest on all five trauma indicators with 48.5% in multi-dimensional crisis; (H6) SNAP gap widening under extreme poverty (5.3 to 67.3 per 1,000), rejecting narrowing hypothesis; (H7) Massive regional clustering with 92-98% of variance between states, identifying three crisis zones: Mississippi Delta, Appalachia, and Native regions. ***$p<.001$

Given that 95%+ of trauma variance is regional, policies must address regional economic forces. Federal investment in distressed regions—infrastructure, education, economic diversification—could be more effective than state-level programs. Historical models include the Tennessee Valley Authority and Appalachian Regional Commission, though these have shown mixed results.

2. Targeted SNAP Outreach
The SNAP enrollment gap widening under extreme hardship suggests that outreach efforts should be most intensive in high-trauma Republican counties. Reducing stigma through community-based programming, simplifying enrollment, and increasing benefits may help. However, our data suggest enrollment increases alone are insufficient—structural change is needed.

3. Violence Intervention in Rural Democratic Counties
Rural Democratic counties' extreme violence (M = 18.51 per 100,000) rivals that of major cities but receives less attention and fewer resources. Evidence-based violence intervention programs (focused deterrence, hospital-based programs) should be adapted for rural contexts.

4. Addressing Systemic Segregation
Our finding that % Black-violence correlations are strong in both urban contexts ($r > 0.7$) suggests that integration efforts and anti-discrimination enforcement must continue. Fair housing, inclusive zoning, and school integration policies could reduce concentrated disadvantage.

5. Opioid Crisis Response in Appalachia
Appalachian counties' extreme overdose rates (53.2 per 100,000) require sustained medication-assisted treatment access, harm reduction services, and economic opportunity creation to address root causes.

6. Multi-Dimensional Approaches for Multi-Dimensional Crisis
Rural Democratic counties' compound disadvantage (48.5% in crisis on 3+ indicators) cannot be addressed by single-issue programs. Comprehensive place-based initiatives addressing poverty, violence, family support, substance abuse, and food insecurity simultaneously may be necessary.

Critically, policies must be regionally scaled. When 98% of food insecurity variance is between states, county-level food banks cannot solve the problem. Regional approaches coordinating across states may be essential.

LIMITATIONS

1. Cross-sectional design: We cannot establish causality. While we argue that historical and economic forces produce trauma, reverse causation (trauma producing political patterns) is possible, though theoretically less plausible.

2. Missing data: Homicide rates were missing for 54% of counties (primarily small, rural counties with few events). This likely underestimates rural violence when present.

3. Ecological fallacy: County-level patterns may not reflect individual experiences. Not all children in high-trauma counties are traumatized, and some children in low-trauma counties experience severe adversity.

4. SNAP enrollment: We measure enrollment, not need or benefit adequacy. High enrollment could reflect either high need or effective outreach. Low enrollment could reflect low need or access barriers.

5. Political classification: We used presidential vote shares, which may not capture local political culture. Some rural Democratic counties (Black Belt) differ dramatically from urban Democratic counties.

6. Spatial analysis: Without geographic boundary files, we could not compute true Moran's I statistics. Our ICC approach provides evidence of regional clustering but cannot identify specific spatial patterns (e.g., hotspots).

7. Racial composition analysis: Our % Black variable captures presence but not segregation, integration, or wealth distribution within counties. More refined measures (dissimilarity index, isolation index) would strengthen conclusions.

8. Confounding: Many variables correlate with political geography (population density, education, industry composition). While we argue for causal mechanisms, unobserved confounders may explain associations.

FUTURE DIRECTIONS

1. Longitudinal analysis: Following counties over time could establish whether political transitions (flipping from Republican to Democratic) alter trauma trajectories, supporting causal interpretation.

2. Individual-level data: Linking county characteristics to individual ACEs using restricted-access datasets (BRFSS, NSCH) could test ecological patterns at the individual level.

3. Mechanism testing: Qualitative research in high-trauma counties could dentify specific mechanisms—what policies, practices, or cultural factors produce observed patterns?

4. Intervention evaluation: Natural experiments (SNAP policy changes, violence intervention rollouts) could test whether our hypothesized mechanisms are causal.

5. True spatial analysis: Obtaining county shapefiles and computing Moran's I, LISA statistics, and spatial regression models could identify specific clusters and spillover effects.

6. Segregation measurement: Incorporating dissimilarity indices, isolation indices, and wealth distribution data could test segregation mechanisms more directly.

7. Historical analysis: Linking historical data (slavery intensity, mining employment, reservation establishment dates) to contemporary trauma could test historical legacy hypotheses.

CONCLUSION

Childhood trauma in America is not random, nor is it primarily individually determined. Rather, it follows deep structural patterns shaped by history, political geography, and regional economic forces. Where a child is born—Mississippi Delta versus suburban Connecticut, Appalachian coalfield versus California coast—determines trauma exposure more powerfully than most recognized social determinants.

Three findings particularly demand attention:

First, Rural Democratic counties—including the Black Belt, Appalachia, and Native reservations—experience multi-dimensional crisis that current policies cannot overcome. These are America's most distressed communities, yet they receive limited attention and resources compared to urban poverty.

Second, systemic racism's effects on violence and disadvantage operate across all urban contexts, not just Democratic cities. Even affluent Republican suburbs show strong correlations between % Black and violence, suggesting segregation's consequences transcend local political boundaries.

Third, geography shapes trauma with extraordinary power. Over 95% of variance in childhood trauma is regional, suggesting that county or even state-level interventions may be insufficient. Regional approaches addressing historical legacies, economic abandonment, and structural racism may be necessary.

These patterns persist across generations. Children born in the Mississippi Delta today inherit poverty and violence rooted in slavery 160 years ago. Children in Appalachian coalfields inherit economic devastation from an extraction economy that has moved on. Children on reservations inherit the legacies of genocide and forced isolation. Until we address these deep structural forces—not just with incremental policy adjustments but with sustained regional investment and structural transformation—the geography of childhood trauma will remain America's enduring map of inequality.

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BEYOND THE CRITICAL INCIDENT: UNDERSTANDING THE CUMULATIVE IMPACT OF OCCUPATIONAL STRESS AND TRAUMA EXPOSURE IN FIRST RESPONDERS

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ABSTRACT

First responders routinely face difficult calls, human suffering, disrupted sleep, organizational pressures, and the expectation that they will be ready for the next alarm regardless of what came before. Much of the traditional discussion of traumatic stress has centered on the critical incident. That model remains important, but it does not always reflect how stress develops over a career. This article examines first responder stress from a cumulative and multidimensional perspective, drawing on peer-reviewed literature as well as clinical and operational experience. Key areas include changes in sleep, mood, relationships, coping, functioning, organizational stress, and social support. The discussion also provides practical strategies for first responders, clinicians, peer support personnel, CISM teams, chaplains, supervisors, and emergency service organizations. The central premise is simple: exposure is not the same as disorder, and resilience should not be confused with invulnerability. Sometimes there is one defining call. Sometimes there is no single call at all. Recognizing changes from a first responder's usual baseline may create opportunities for support before a problem becomes a crisis.

Keywords: first responders, traumatic stress, cumulative exposure, occupational stress, resilience, peer support, sleep, crisis intervention

BEYOND THE CRITICAL INCIDENT

For years, much of the conversation about traumatic stress among first responders has centered on a single critical incident: a pediatric fatality, a line-of-duty death, a mass-casualty event, a heavy trauma, a colleague's suicide, or the call everyone at the station knows was a bad one. Those calls certainly matter, and they always will. But they're not the whole story.

For many first responders, there may never be a single call they can point to and say, "That was the one." Instead, the weight may come from years of being there: serious injuries, unsuccessful resuscitations, frightened families, violence, death notifications, difficult extrications, and ordinary calls that occasionally linger longer than expected.

Then there's everything that seems to show up around the calls: interrupted sleep, long shifts, staffing issues, administrative pressure, family responsibilities, and the expectation that when the tones drop again, we'll be ready to go. Most first responders continue to function well despite these demands. A difficult call doesn't automatically lead to PTSD, and exposure shouldn't be confused with psychological injury. At the same time, resilience shouldn't be mistaken for immunity.

Research supports that distinction. First responders vary widely in their responses to potentially traumatic events, and outcomes are shaped by factors beyond exposure alone (Arena et al., 2025; Hoell et al., 2023). The more useful clinical question, therefore, is not whether every difficult call causes harm, but whether we're paying attention when something begins to

change. Sometimes the question isn't simply, "What happened to you?" It's, "What have you been carrying?"

EXPOSURE IS ONLY PART OF THE PICTURE

One of the most important things we can do in first responder mental health is to avoid moving too far in either direction. We shouldn't dismiss every reaction as simply part of the job, but we also shouldn't turn every normal response to a difficult experience into a diagnosis.

A firefighter who has trouble sleeping after a pediatric call doesn't automatically have PTSD. A paramedic who keeps thinking about an unsuccessful resuscitation doesn't automatically have a disorder. Feeling irritable, distracted, sad, angry, or unsettled for a period of time after something difficult can be part of being human. PTSD is a specific clinical condition. Exposure is only one part of the picture. Symptoms, duration, distress, impairment, and other possible explanations all matter. That clinical distinction is especially important for first responders because the culture often pulls in two opposing directions. One message says, "Suck it up; this is the job." The other can make it sound as though anyone exposed to enough difficult calls will eventually break. These are extremes, and extreme messages like these tend to be inaccurate and unhelpful.

People also change over the course of a career. A particular call at 25 may feel very different at 45, when you have a patient the same age as your child, spouse, or parent. A difficult incident after several nights of poor sleep may land differently than it would after sufficient rest. A tough call may also land differently when someone is already dealing with a divorce, a personal loss, illness in the family, financial stress, or other challenges outside the job. That's why a good assessment requires more than asking about the worst call. It requires understanding the person who went on the call.

PUT IT INTO PRACTICE: CHECK YOUR BASELINE

Instead of asking, "Am I okay?" ask a more useful question: "What's different about me now compared to three or six months ago?"

Take a quick look at five key areas:

SLEEP - MOOD - RELATIONSHIPS - COPING – FUNCTIONING

The goal isn't to diagnose yourself but to notice changes. If sleep is getting worse, patience is shorter, relationships are becoming strained, alcohol use is becoming a more frequent way to unwind, or things you normally enjoy are disappearing from your life, that's information worth paying attention to. Change is helpful information. It doesn't automatically become a diagnosis.

WHAT WE BRING TO THE CALL

Putting on the uniform and equipment doesn't erase what happened before someone walked into the station. First responders have marriages, children, aging parents, financial concerns, illnesses, losses, relationship problems, and histories that predate the tones going off. Research underscores the importance of looking beyond occupational exposure alone. In a study of police officers, paramedics, firefighters, and search-and-rescue personnel, personal-life traumatic events were frequently identified as the experiences that affected responders most (Wild & Chang, 2022).
That finding doesn't minimize what happens on the job. It reminds us that the person responding to someone else's emergency may already be carrying something of their own. When a first responder begins to struggle, I don't think the goal should always be to identify the call. Sometimes there's one. Sometimes there isn't. I'm often more interested in what's changed, what else is happening in the person's life, how the individual is sleeping, how they're coping, and whether the things that usually help are still helping. This isn't simply a trauma assessment. It's an assessment of the whole person.

PUT IT INTO PRACTICE: WHAT AM I CARRYING?

Every so often, ask yourself four questions:

- What am I carrying from work?
- What am I carrying from home?
- What haven't I had a chance to recover from?
- What's taking more out of me than it normally would?

The answers don't have to be dramatic. Sometimes several manageable things become much harder to manage when they arrive at the same time.

WHEN THE BUCKET FILLS SLOWLY

We often use the image of a bucket filling over time. It's not a perfect clinical model, but most first responders understand it right away. Not every call adds the same amount to the bucket. Some calls barely register. Others take up more space. Some things work through with time, conversation, sleep, exercise, family, humor, faith, peer support, counseling, or simply getting back into a normal routine. Other experiences are harder to put down.

Meanwhile, life keeps adding to the load. Research on coping among first responders supports what many clinicians and peers observe in practice: the way someone responds to stress matters, and avoidance or disengagement is often linked to poorer adjustment (Dautovich et al., 2023). Coping can take many forms, and effective strategies may change over time. Paying attention to those changes can help us recognize when it may be useful to adapt, adjust, add, or strengthen the ways we manage stress.

Warning signs are often subtle. Sleep patterns may shift. Patience may shorten. Someone stops going to the gym, stops hanging around after the call, drinks a little more often, becomes more cynical, or shows less patience at home. None of those signs, by themselves, establish a diagnosis. They tell us to pay attention. In emergency services, we do this all the time. We notice when an engine sounds different, when a vital sign changes, or when something on scene doesn't look quite right. We don't have to wait for complete failure before checking it out. We can approach behavioral health the same way. Again, the question doesn't always have to be, "Is this person sick?" It can be, "What's changed?"

PUT IT INTO PRACTICE: KNOW YOUR YELLOW LIGHTS

Most people recognize the idea of red flags or red warning lights. I think it's just as important to know your yellow lights—the early signs that something may need attention. That might mean changes in sleep or increased irritability. It could mean withdrawing from the crew, exercising less, drinking more often, losing patience at home, or enjoying things less. My three yellow lights are:

1. _____
2. _____
3. _____

When I notice them, I will:
_____

The goal is to notice yellow before it turns to red.

SLEEP, FATIGUE, AND RECOVERY

Sleep is one of the easiest problems to normalize in emergency services. We joke about being tired because, quite often, everyone is tired, but there's a difference between being tired after a busy night and living with a pattern of inadequate or poor-quality sleep. Research on first responders has consistently identified sleep disorders, fatigue, and disrupted sleep as meaningful occupational health concerns (Huang et al., 2022; Marvin et al., 2023).

Clinically, sleep matters because sleep disruption can mimic symptoms of a range of other conditions. Irritability, poor concentration, forgetfulness, emotional reactivity, low motivation, and increased reliance on caffeine may reflect psychological distress, inadequate sleep, a sleep disorder, occupational fatigue, or a combination of these factors. That's why "How are you sleeping?" can tell us a lot. It can help us better understand what may be going on.

PUT IT INTO PRACTICE: ASK THE RECOVERY QUESTION

After a difficult call, instead of automatically asking, "Are you good?" try asking, "What do you need to recover from this?" It's a small change in wording, but it can open the door to a very different conversation. "Are you good?" often invites a quick yes-or-no response, while asking about recovery encourages the person to consider what might actually help.

Sometimes the answer may be "nothing right now." Other times, it may be food, hydration, sleep, exercise, time with family, a conversation with someone they trust, a few minutes alone, or additional support. The goal is not to prescribe a response or assume that a difficult call has caused a problem. It's to create an opportunity for the first responder to identify their own needs and recognize that recovery after a demanding experience can take different forms.

The same question can also be useful as a self-check: What do I need to recover from this? Asking it before stress begins to accumulate can make recovery a routine part of the job rather than something we think about only when we're struggling.

WHEN COPING STARTS TO CHANGE

Alcohol is another area where change matters more than assumptions. Having a drink doesn't necessarily mean someone's struggling. At the same time, alcohol can be an easy way to quiet the mind, fall asleep, or create distance from a difficult shift. Research has identified hazardous alcohol use as a concern in trauma-exposed occupations, including first responder populations (Irizar et al., 2021). The more useful clinical question may not be "Do you drink?" but rather "Has the way you drink changed?"

The same question applies to other coping mechanisms. Are you exercising because it helps, or because you can't tolerate sitting still? Are you working overtime because you enjoy it, or because you don't want to go home? Are you spending time alone because you need to recharge, or because you're trying to avoid others? These behaviors alone don't always tell the whole story. The change, the purpose it serves, and the impact on functioning often provide more.

THE TRANSITION BETWEEN WORK AND HOME

Emergency service work demands remarkably fast transitions. One minute you may be eating dinner or trying to sleep. The next minute, you may be performing CPR, treating a badly injured child, managing a violent scene, or standing with a family whose life has just changed. Then the call ends, the paperwork is finished, and eventually you go home.

The mind and body don't always shift gears as quickly as the schedule demands. I encourage first responders to establish a transition routine. It doesn't need to be elaborate. Changing clothes, showering, walking, exercising, listening to music, or sitting quietly for a few minutes before entering the house can help create a boundary between one role and the next.

I sometimes think of this as "leaving your boots at the door." That doesn't mean pretending the call didn't happen or that everything from the shift can be left behind. It means creating a deliberate moment to recognize that you're moving from one role to another. The goal is to give your mind and body a chance to shift gears before stepping into your role as a spouse, parent, friend, or whatever comes next.

PUT IT INTO PRACTICE: THE 60-SECOND RESET

Not every difficult moment needs a complicated intervention. Sometimes we just need a minute.

PLANT - Put both feet firmly on the floor or ground.

EXHALE - Let your breathing slow naturally. Don't force a huge breath; simply let the exhalation become unhurried.

RELEASE - Check your jaw, shoulders, hands, and abdomen. Let go of any tension you don't need.

ORIENT - Look around and remind yourself where you are and what's happening right now.

CHECK. Ask, "What do I need before I move on?"

THE CALL ISN'T ALWAYS THE HARDEST PART

Not all occupational stress in emergency services stems from trauma. Staffing shortages, mandatory overtime, leadership problems, interpersonal conflicts, disciplinary issues, administrative demands, public scrutiny, inadequate equipment, and a sense that the organization doesn't have your back when you need it can wear people down, too. Research supports addressing these organizational and interpersonal stressors rather than assuming that mental health difficulties in first responders always stem from

exposure to traumatic calls (Kshtriya et al., 2020; Bevan et al., 2022). This is an important clinical point because a first responder may handle an extraordinarily difficult call and still be more affected by what happens afterward – being blamed, ignored, second-guessed, isolated, or unsupported. Sometimes the call is only part of the story.

PEER SUPPORT: NOTICE BEFORE YOU NEED TO FIX

First responders have always relied on one another. Long before peer support teams had names, people talked at the kitchen table, in the ambulance bay, on the apparatus floor, or during the ride back to quarters. Those conversations make a difference. Research has consistently linked stronger perceived social support with better mental health outcomes among first responders (Prati & Pietrantoni, 2010; Kshtriya et al., 2020).

Peers can play an important role by noticing changes, starting conversations, listening, and connecting someone with additional support when needed. The strength of peer support often lies in being present, approachable, and willing to talk. Sometimes the most useful opening is also the simplest: "You haven't seemed like yourself lately. How are you doing?"

Being a good peer doesn't mean becoming someone's therapist. The role is to listen, support, and help someone take the next step when additional help may be needed. Sometimes that means continuing the conversation. Other times, it may mean connecting the person with a clinician, chaplain, peer support team, CISM resource, or another appropriate support source.

PUT IT INTO PRACTICE: NOTICE-ASK-STAY

NOTICE - Pay attention to meaningful changes from the person's usual baseline.

ASK - Find a private moment to say what you have noticed. Keep it simple and genuine.

STAY - Listen. Don't immediately fix, diagnose, minimize, interrogate, or turn the conversation into your own story.

If the person needs more support than you can provide, help make the connection. Don't simply hand over a phone number and disappear. A peer doesn't need all the answers. Sometimes being willing to stay in the conversation is enough to get the next step started.

SEEKING HELP SHOULDN'T BEGIN AT CRISIS

A wide gap separates doing well from being in crisis, and people can spend a long time in that middle ground. They may tell themselves what they're experiencing isn't serious enough to warrant support, or worry about confidentiality, someone else's opinions, or what asking for help might mean for their job. Research shows that stigma and perceived barriers to care remain significant concerns among first responders (Haugen et al., 2017). Making support easier to access early gives first responders more options before problems pile up in their lives. Changes in sleep, relationships, alcohol use, mood, or work performance can all be reasons to check in, reach out, or consider additional support. Help can begin well before someone reaches a crisis.

The same principle applies to peers and supervisors. You don't need a diagnosis to recognize that someone seems off. The goal is to create a culture where noticing, asking, listening, and connecting are accepted parts of looking out for one another. Sometimes the best time to respond is when the yellow lights first appear.

FROM CRITICAL INCIDENT RESPONSE TO ONGOING AWARENESS

Critical incident support still has an important place. Some calls and events may warrant outreach, peer support, crisis intervention, or professional follow-up. At the same time, research on preventing later mental health problems through a single post-incident intervention has produced mixed findings (Tan et al., 2022). That should encourage us to avoid a cookie-cutter approach and instead consider the individual, the circumstances, and what type of support may be most useful.

A strong behavioral health approach goes beyond what happens after a bad call. It includes education, peer support, leadership that understands behavioral health, confidential pathways to professional care, attention to

sleep and recovery, family awareness, and a culture that views asking for help as a strength rather than a weakness. We already understand the importance of prevention in other areas of emergency services. We maintain equipment before it fails, train before an emergency occurs, pre-plan so we know how best to handle a situation if it arises, and identify hazards before anyone is hurt. Behavioral health deserves the same mindset.

For clinicians, that also means understanding the culture. Knowing the first responder's role, work history, schedule, family situation, coping style, peer relationships, and life outside the job can reveal things that a symptom checklist alone can't. Cultural competence means understanding enough about the world the person works in to ask better questions, place their experiences in context, and better understand the person sitting in front of you.

PRACTICAL TAKEAWAYS

1. **Look for change.** Pay attention to the first responder's baseline and to small, persistent changes in sleep, mood, behavior, relationships, or functioning. Early changes may tell us more than waiting for an obvious crisis.

2. **Look at the whole picture.** Ask what the person is carrying. One call may be part of the picture, but so may family stress, poor sleep, organizational problems, relationship difficulties, or years of accumulated exposure.

3. **Treat recovery as part of readiness.** Sleep, relationships, exercise, recreation, time away from the job, and meaningful connection all help sustain the person who has to answer the next alarm. Recovery is part of staying ready for what comes next.

4. **Make checking in routine.** Check on people when things are going well, too. Normalizing everyday conversations can make harder conversations easier when they're needed.

5. **Recognize when additional support may help.** Grounding, humor, peer support, exercise, family, and healthy routines can all be valuable. When symptoms persist, worsen, interfere with daily life, contribute to unsafe substance use, or involve thoughts of suicide or self-harm, professional assessment and treatment may be appropriate.

6. **Know when to call for backup.** Good coping includes recognizing when you need additional support and being willing to use it.

CONCLUSION

First responders do difficult work. They frequently step into situations most people spend their lives trying to avoid, and then they are expected to be ready when the next call comes in. Most adapt, recover, and keep moving forward. That resilience deserves recognition, but resilience doesn't mean the job leaves no mark.

One challenge in emergency services is that we become very good at functioning. We learn to put the gear back in service, finish the paperwork, clear the call, and move on to whatever comes next. That ability helps us do the job. But continuing to function doesn't always mean we've left the call – or its impact – behind.

Taking care of our people means recognizing both sides of that reality. We can respect the strength, commitment, and resilience throughout emergency services while also making room for times when someone may need help or support. Those two ideas can – and should – coexist. Asking for help can be part of resilience, and offering support can simply mean being there for one another.

We should approach behavioral health much like the other parts of readiness we already value. We prepare, maintain, train, and look for potential problems because we know that small things matter. Our behavioral health deserves that same consideration.

We routinely check our apparatus, equipment, and crews. We should get into the habit of checking ourselves, too. Sometimes there's one call. Sometimes there are a thousand. And sometimes the most useful question is simply, "What have you been carrying?"

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DO YOU HAVE TRAUMA-INFORMED TRAINING IN PLACE WITHIN YOUR SCHOOL?

If so, does it:

- Include live and virtual coaching sessions, designed to discuss your specific needs in a confidential manner
- Offer certification courses that support the implementation of trauma-informed, resilience-focused practices and strategies within schools
- Transform school culture by identifying your strengths, weaknesses, and attitudes that are impacting your results

If not, or if you're not sure, I'd welcome the chance to share how Starr Commonwealth is leading trauma-informed care at the district, school, and professional levels.

Without the resources to react to students experiencing trauma, educators commonly feel overwhelmed and ill-equipped to address the needs of their students.

This is why Starr Commonwealth exists. We've made it our mission to empower professionals to build resilience in children, families, and communities across the world.

Through online education, in-person training and coaching, and direct behavioral health services, educators are bringing out the best in every child, parent, and community.

If you'd benefit from a certified trauma-informed and resilience-focused program to bring into your school, we should talk.

Pat Murphy
Professional Learning Advisor
pat@starrcommonwealth.org



Survivors.org (https://survivors.org/) is a survivor-centered nonprofit organization dedicated to supporting individuals impacted by sexual violence, domestic violence, abuse, and trauma through healing-centered advocacy, education, and community support.

Through virtual healing circles, awareness initiatives, survivor resources, and community outreach, Survivors.org works to create safe and empowering spaces where survivors feel seen, supported, and connected. Programs such as the BIPOC Healing Circle provide opportunities for healing, reflection, and meaningful conversation within a trauma-informed environment.

The organization continues to collaborate with schools, nonprofits, advocates, and community leaders to expand conversations surrounding prevention, mental health, resilience, and survivor empowerment.

At Survivors.org, the mission is simple but powerful: to remind survivors they are not alone and that healing is possible through community, compassion, and support.

Learn more, connect, or support the mission at:
www.survivors.org (https://survivors.org/)

PUBLICATIONS, WORKSHOPS AND TRAININGS BY ACADEMY MEMBERS

Academy members can have their publications, trainings and workshops announced in the *Journal of the American Academy of Experts in Traumatic Stress*. The Academy can also send emails to all members and Academy associated networks. Any questions regarding announcements, please contact Annmarie Arleo, Senior Membership Relations Specialist, at aarleo@aaets.org.

WORKSHOP AND PROFESSIONAL PRESENTATIONS BY ACADEMY MEMBER JOHN "PAUL" MANLEY



Clarity Before Crisis™: From Warning Signs to Leadership Decisions
A prevention-focused program examining how leaders can recognize behavioral concerns, assess available information, and make clear, defensible decisions before a situation escalates into a crisis.

Trauma-Informed, Prevention-Focused Strategies for Workplace Violence
A trauma-informed approach to recognizing, preventing, and responding to workplace violence while considering the impact of traumatic stress on employees, organizations, and those involved in critical incidents.

Behavioral Risk Recognition and Threat Assessment
An introduction to recognizing concerning behaviors, identifying patterns of escalation, gathering relevant information, and determining when a behavioral concern requires further assessment or intervention.

High-Stakes Communication and De-Escalation
A practical program focused on communication strategies for situations involving heightened emotion, conflict, anger, or potentially escalating behavior. Participants learn how communication can support safety while maintaining dignity and reducing unnecessary escalation.

Peer Support and Acute Traumatic Stress Management
A practical program addressing the immediate needs of individuals affected by critical incidents or other potentially traumatic events. Topics include recognizing acute traumatic stress reactions, providing supportive peer intervention, understanding when additional assistance may be needed, and helping individuals connect with appropriate resources and support.

The Executive's First 24 Hours After a Workplace Threat
A leadership-focused program addressing the critical decisions that follow a workplace threat, including initial information gathering, employee safety, communication, coordination, documentation, and determining appropriate next steps while facts may still be incomplete.

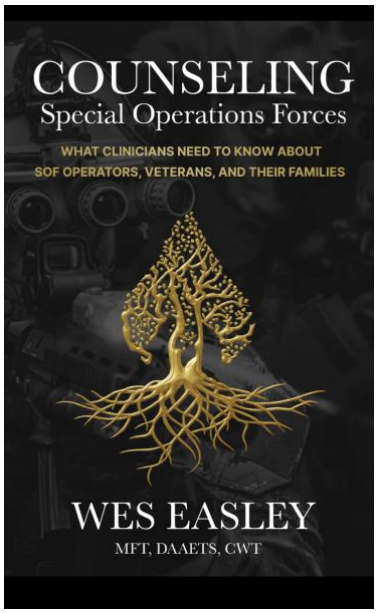
Professional Website: Risk Mitigation Technologies LLC
https://riskmitigationtechnologiesllc.com/

Selected Professional Resources: P.R.E.V.A.I.L.™ Leadership System / Clarity Before Crisis™
https://riskmitigationtechnologiesllc.com/prevail-leadership-system/

De-Escalation Training: https://riskmitigationtechnologiesllc.com/de-escalation-training/

PUBLICATION BY ACADEMY MEMBER WES EASLEY

COUNSELING SPECIAL OPERATIONS FORCES: WHAT CLINICIANS NEED TO KNOW ABOUT SOF OPERATORS, VETERANS, AND THEIR FAMILIES



Special Operations Forces (SOF) personnel serve in some of the world's most demanding operational environments, yet many mental health professionals receive little formal training in understanding their unique culture, operational experiences, and psychological needs.

*Counseling Special Operations Forces*provides clinicians with an evidence-informed guide to effectively working with SOF operators, veterans, and their families. Drawing upon current research and the author's combined experience as a combat veteran, former law enforcement officer, and embedded mental health clinician, the book explores topics including operational stress, combat trauma, moral injury, traumatic brain injury, resilience, family systems, identity transitions, and culturally competent treatment approaches.

Designed for psychologists, counselors, social workers, psychiatrists, marriage and family therapists, graduate students, military clinicians, Veterans Affairs providers, and professionals serving first responders, this book bridges the gap between military experience and clinical practice.

Whether treating active-duty operators, transitioning veterans, or tactical professionals in civilian settings, clinicians will gain practical knowledge to build trust, improve therapeutic outcomes, and provide culturally responsive care to one of the world's most resilient—and often misunderstood—communities.

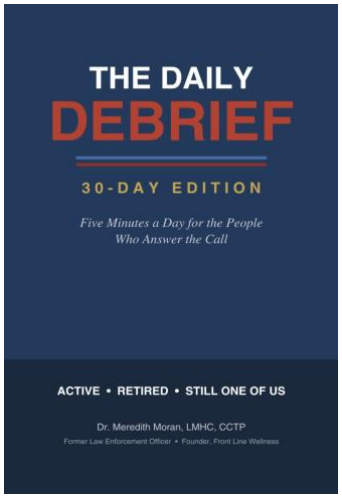
Wes Easley, LMFT, DAAETS, CWT, is an embedded mental health clinician with the Washoe County Sheriff's Office, author, educator, Army veteran, and former law enforcement officer. He specializes in trauma, operational stress, moral injury, and resilience among Special Operations Forces, military veterans, first responders, and their families. Wes is the author of *Counseling Special Operations Forces: What Clinicians Need to Know About SOF Operators, Veterans, and Their Families* and presents nationally on psychological health, peer support, and culturally competent behavioral health care. His work focuses on bridging operational experience with evidence-informed clinical practice.

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TWO NEW PUBLICATIONS BY ACADEMY MEMBER DR. MEREDITH MORAN

Dr. Meredith Moran is a licensed trauma therapist and former law enforcement officer who has spent her career with first responders and the people who love them, this companion blends plain-language guidance with space to process what you're carrying.

THE DAILY DEBRIEF: A 5-MINUTE GUIDED JOURNAL FOR FIRST RESPONDERS



Five minutes. That's the whole assignment.

You've briefed a thousand shifts and debriefed a thousand calls. This journal is the same drill, pointed at your own life — two minutes in the morning to brief the day, three minutes at night to debrief it, so the shift stays where it belongs.

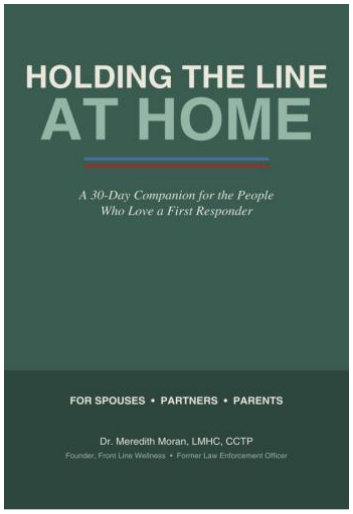
This isn't a diary. Nobody's asking you to write about your feelings for an hour. It's a checklist for your head, built in the language of the job: a Morning Brief, an Evening Debrief, and a personal AAR every night — sustain what worked, adjust one thing for tomorrow.

- 30 undated daily pages — miss a day, nobody's writing you up
- Weekly AARs tracking sleep, fuse length, connection, and purpose
- Heavy Day pages for the calls that stay with you
- A tactical breathing quick-reference and 24/7 responder-specific crisis lines
- A 30-Day Review to see how far you've come

For firefighters, police officers, EMS, dispatchers, and corrections — active duty or retired. Because the tones stop, but the wiring doesn't.

CLICK HERE FOR MORE INFORMATION

HOLDING THE LINE AT HOME: A 30-DAY COMPANION FOR THE SPOUSES, PARTNERS, PARENTS AND FAMILIES OF FIRST RESPONDERS



You love someone who runs toward the worst. This is for you.

You're the one still up when they get home — reading the shift in their shoulders before they say a word, holding the household together around a schedule that never asks your opinion. Loving a first responder is its own kind of service, and nobody hands you a manual for it. This is that manual — and a place to put your own load down.

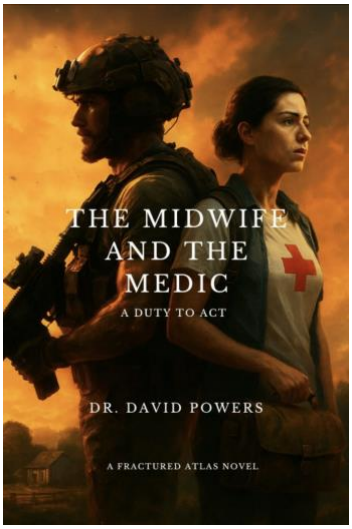
- Guidance that makes sense of what you're seeing — why the distance, the short fuse, the silence, and the hypervigilance are about the job, not about you
- How to tell a hard day from a warning sign — and exactly what to do about each
- 30 days of guided pages — a few minutes for them, and a few minutes for you, because you're carrying more than anyone tells you
- "Hard Day" pages — including one just for you — for the bad-call nights, the anniversaries, the stretches when they go quiet
- Weekly check-ins and a full page of confidential crisis and support lines for the whole family

For the spouses, partners, parents, and adult children of police officers, firefighters, EMS, dispatchers, and corrections — active duty or retired. Because you hold the line at home. Let someone hold it for you sometimes.

CLICK HERE FOR MORE INFORMATION

NEW PUBLICATION BY ACADEMY MEMBER DR. DAVID POWERS

THE MIDWIFE AND THE MEDIC



The Midwife and the Medic is a disaster thriller grounded in the realities of emergency response, humanitarian crisis, and the psychological toll of serving others. Inspired by the devastation of Hurricane Helene and informed by author Dr. David W. Powers' decades of experience as a U.S. Marine, Army combat medic, paramedic, and disaster medic, the novel follows a former combat medic and a rural midwife as they navigate the collapse of infrastructure, overwhelming medical needs, ethical dilemmas, and the emotional weight of caring for others when outside help cannot arrive. More than an action story, it offers a compelling exploration of leadership under pressure, moral injury, compassion fatigue, resilience, and post-traumatic growth. Through authentic characters and realistic crisis scenarios, The Midwife and the Medic provides both an engaging novel and a powerful reminder that, in every disaster, the greatest resource is often ordinary people choosing to serve when it matters most.

When I wrote The Midwife and the Medic, I didn't set out to write a thriller.
I set out to write a thank-you note.

To the medics, midwives, and first responders who run toward the danger.
To the people who hold a flashlight when the generator fails.
To the ones who believe faith and duty still mean something.

This story was born in the aftermath of real storms I worked and long nights on disaster deployments. It's fiction built from the truth, the kind you only see when the world goes quiet and the radio still crackles.

It's only the beginning of a tale for people who care about stories that matter. This will be the first novel in The Fractured Atlas series, and the start of a growing world where truth bleeds through the cracks."

The Story

When Hurricane Helene tears through the mountains of North Carolina, former combat medic Sam Jenkins finds himself standing guard at a powerless rural clinic, haunted by ghosts and running on duty alone.

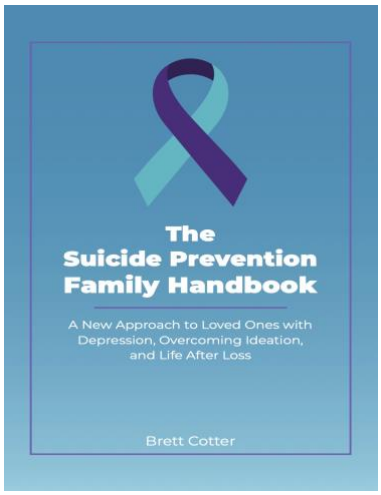
Then Jen Hayes, a no-nonsense midwife with grit and grace, bursts through the door carrying a laboring mother and a storm-shattered mission. Together, in the flicker of failing lights and howling wind, they deliver more than a baby. They deliver hope.

But as floodwaters rise and FEMA convoys roll in, they uncover something darker, a covert operation rewriting who lives and who disappears. Between collapsing bridges, armed locals, and a secret unit called the 793rd Psyops Detachment, Sam and Jen must decide whether saving lives means defying orders.

This is the story that is launching The Fractured Atlas Universe, a blend of realism, faith, and firelight born in the storm.

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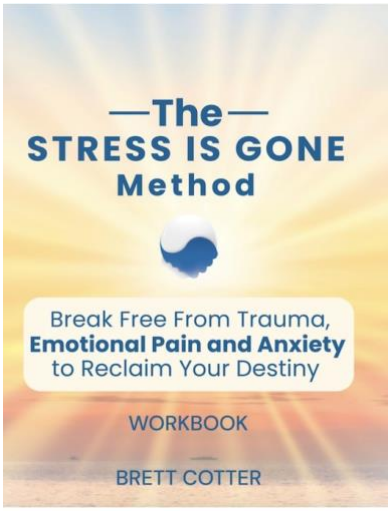
TWO NEW PUBLICATIONS BY ACADEMY MEMBER BRETT COTTER



THE SUICIDE PREVENTION FAMILY HANDBOOK

The Suicide Prevention Family Handbook is a compassionate and practical resource for those supporting loved ones through depression, anyone struggling with suicidal ideation, and those who feel overwhelmed with grief from losing a loved one. It offers actionable strategies and tools that complement traditional treatments, empowering families to foster connection and resilience. In Chapter 1, readers learn how to best support loved ones suffering from depression. In Chapter 2, individuals with depression will find a clear process to help overcome their own suicidal thoughts. In Chapter 3, exercises to help people feel emotionally and spiritually reconnected with their lost loved ones are included. This book is a vital asset for mental health professionals and holistic health practitioners. Readers are equipped with the words, body language, and strategies to save lives.

CLICK HERE FOR MORE INFORMATION ABOUT



THE STRESS BE GONE METHOD

The Stress Is Gone Method is a self-care system that empowers people with tools to overcome stress, emotional pain, anxiety, negative thinking, and trauma. This interactive workbook provides you with more than just stress-relief techniques; it guides you to release the repressed fear that creates additional emotional pain and helps you embody the new beliefs necessary to produce the life of your dreams. You'll discover your true power as you effectively respond to stress from:

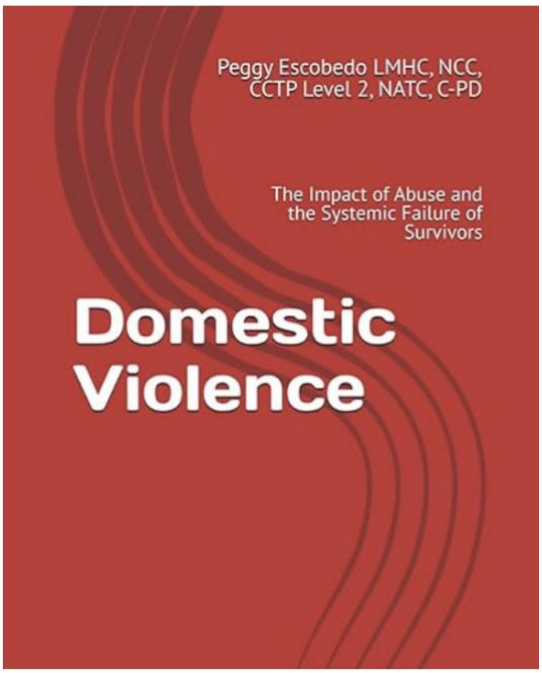
- Traumatic Events
- Overwhelming Family Situations
- Work, Finances, or School Stress
- Abusive or Narcissistic Relationships
- Personal or Family Health Crises
- Generational or Ancestral Trauma
- Loss of a Loved One

This book allows stress to enlighten us as triggers become teachers and self-love fills the hole that trauma left in our soul.

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NEW PUBLICATION BY ACADEMY MEMBER PEGGY ESCOBEDO

DOMESTIC VIOLENCE: THE IMPACT OF ABUSE AND THE SYSTEMIC FAILURE OF SURVIVORS

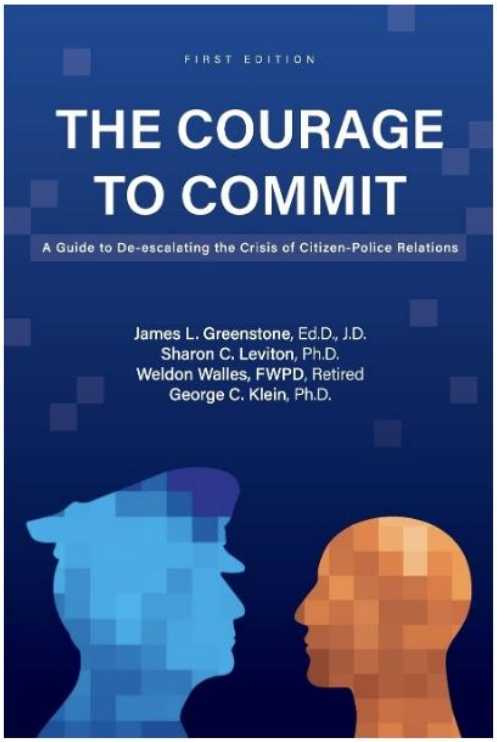


This work offers a critical analysis of the institutional barriers that prevent survivors from achieving true safety, drawing on her 25 years of linical experience this book aims to explore the societal blind spot that prevents legal, medical, and religious institutions from identifying the abuse and coercive control. For those of us working in crisis management and traumatic stress, we often witness the "Secondary Crime Scene", the moment a survivor reaches out for help only to be re-traumatized by the very institutions meant to protect them. This book serves as both validation for survivors and a practical manual for practitioners navigating the support systems for survivors, providing a trauma-informed lens for analyzing institutional responses ranging from the neurobiology of trauma to the "Failure to Protect" paradox in child protection systems. Key topics include "Proxy Abuse by the Gavel," which examines how the legal system is weaponized against survivors and how survivors' trauma symptoms are used to discredit them in the judicial system; how medical and religious sanctuaries become snares; a review of key roles in an abusive relationship and how the dynamics of abuse impacts them. As experts in traumatic stress, we recognize that recovery cannot happen in a vacuum, and this work challenges us to move beyond asking "why they stay" to auditing the systems that offer little to no options but to stay.

CLICK HERE TO ORDER BOOK

The Courage to Commit:

A Guide to De-escalating the Crisis of Citizen-Police Relations



The Courage to Commit: A Guide to De-escalating the Crisis of Citizen-Police Relations is designed to inspire vital dialogue regarding the United States' founding principles, its social covenants, and the relationship between its police force and its communities. Featuring diverse perspectives, the text illuminates the needs to both enact significant changes in policing and examine and fix police-citizen culture.

The book considers the characteristics that make up a good police officer, the place of power in the actions of police officers, Sir Robert Peel' s principles for police work, and the often-tenuous relationship between the police and the community. It also addresses the role of the police during turmoil, the use of force, conflict management, crisis intervention, and de-escalation. Chapters examine the importance of training and supervision for police-citizen encounters, as well as police response to families in crisis. The book discusses potential solutions and presents readers with a framework for improved police-community relations. Throughout the text, vignettes and case studies bring the material to life and encourage lively discussion and debate.

The Courage to Commit is an essential textbook for courses and programs in policing and law enforcement management and administration. It is also an ideal resource for community members, community leaders, elected and appointed officials, and all concerned citizens who are interested in improving police-citizen relations.

James L. Greenstone, Ed.D., J.D. is a psychotherapist, mediator, arbitrator, negotiator, author, professor, police officer, editor-in-chief, military officer, and police behavioral health specialist.

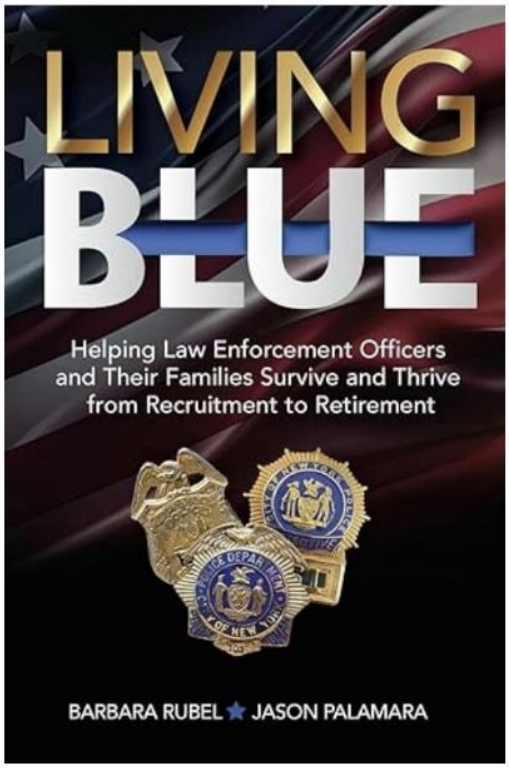
Sharon C. Leviton, Ph.D. holds degrees in education and crisis intervention and serves as a crisis specialist and dispute mediator in private practice.

Weldon Walles is an honorably retired Texas Master Peace Officer who served with the Fort Worth Police Department for 25 years.

George C. Klein, Ph.D. is a professor emeritus at Oakton Community College. He has a doctorate in sociology and criminal justice. He was a part-time police officer, is a trained hostage negotiator, and was a consultant to the FBI.

CLICK HERE TO ORDER THIS BOOK

Living Blue: Helping Law Enforcement Officers and Their Families Survive and Thrive from Recruitment to Retirement



Two perspectives. A retired Cold Case Homicide detective, Jason Palamara, and acclaimed author and thanatologist, Barbara Rubel, whose parents were police officers. As you read this book on law enforcement wellness, you'll notice that each chapter begins with Palamara's memoir, "In My Experience and Lessons Learned" and describes how he coped with on the job traumatic experiences, such as 9/11, homicide of young victims, and LODD.

Barbara Rubel's section, "My Story and Evidence-Based Practices" follows, and includes cutting-edge science, research-based practices, and personal insight. She shares her childhood stories of living blue, as well as the devastating loss of her father, a retired sergeant, who died by suicide while she was awaiting the birth of triplets.

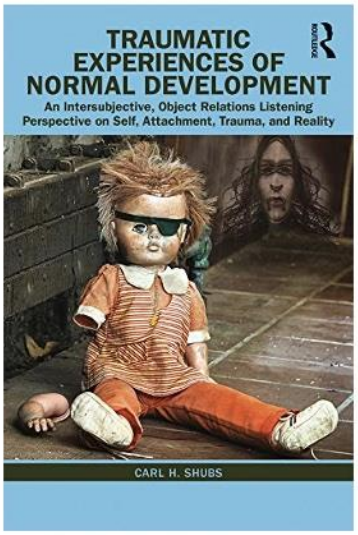
What sets this book apart is its approach to vicarious trauma-informed practices based on the personal experiences of the authors, and that of over 70 law enforcement professionals and experts in mental health.

Living Blue is designed to increase wellness in officers, their families, and ultimately, their communities. In *Living Blue*, you will learn how to:

- Incorporate a vicarious trauma-informed approach to policing.
- Manage compassion fatigue, burnout, secondary trauma, and moral injury.
- Change the culture and stigma that prevents law enforcement professionals from getting help.
- Boost resilience and achieve post-traumatic growth.
- Prevent law enforcement officer suicide.

CLICK HERE TO PURCHASE BOOK

Traumatic Experiences of Normal Development: An Intersubjective, Object Relations Listening Perspective on Self, Attachment, Trauma, and Reality



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

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

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

Reviews

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

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

In this volume, Traumatic Experiences of Normal Development, Dr. Shubs has produced an encyclopedic work on the title subject. He brings to the task his understanding that comes from his clinical experience of working for decades with victims of violent crimes. In addition, he provides, in their own words, the personal theories and interpretations of the leading authorities in the field.

His research comes from a personal, theoretical, and experiential base. This is no more evidenced than in a poem he wrote, "To Be in a Closet," which he inserts at the beginning of his work, where he says, "The final version [of the poem] grew out of my self-awareness regarding my own array of closets and my knowing that each of us has them."

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

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

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When The Solution Becomes the Problem:
Helping Families Struggling with Addiction and Trauma



Denver, Colorado - Barnes Education and Consulting, LLC is excited to announce the launch of Michael Barnes, Ph.D., LAC, LPC's new book, When The Solution Becomes the Problem: Helping Families Struggling With Addiction and Trauma. Dr. Barnes' book, available in digital format and paperback, will provide comprehensive information on addiction and trauma by weaving scholarly literature with real-life scenarios, allowing the book to be approachable to families and professionals.

A report from KFF Health News in July 2023 revealed that nearly 30% of U.S. adults have experienced addiction within their family. This issue deeply affects family dynamics, mental health, and finances for half of those surveyed. Addiction and trauma, as transgenerational issues, significantly influence the well-being of many Americans. When the Solution Becomes the Problem will introduce many families struggling with addiction and trauma to a new approach to the recovery process.

Dr. Barnes is a Diplomate in the American Academy of Experts in Traumatic Stress. He is the Chief Clinical Officer at Foundry Treatment Center in Steamboat Springs, CO. He is also the Founder and Director of the Michael Barnes Family Institute, which is part of NRT Services. Dr. Barnes frequently speaks at local, state, and national conferences on the co-occurrence of addiction and trauma and their impact on the family system. He is also an adjunct faculty member at the University of Colorado Denver and Colorado Mountain College.

Dr. Barnes's book can be purchased on his website (www.drmikebarnes.com), Amazon, and other web-based bookstores. He is available for podcasts, interviews, and other media opportunities to promote the book. Contact Patrick Barnes for scheduling. Patrick can be reached at either 720-484-0647 or pat@barnesedandconsulting.com.

BOOK SUMMARY

Unlike most books on families and addiction that provide prescriptive advice, When The Solution Becomes the Problem takes a different approach. This book partners with families, aiming to help them understand why implementing expert recommendations can be so challenging. By delving into the "why," families gain insights into their current crisis and the factors contributing to it.

The book's primary goals are twofold. Firstly, it aims to provide comprehensive information on addiction and trauma, drawing from scholarly literature while presenting it in a family-friendly style with relatable stories and clinical descriptions. Real-life scenarios woven through the chapters allow readers to recognize themselves and their family's circumstances from fresh perspectives.

Secondly, the book encourages readers to embark on a transformative journey of self-discovery, leading to growth, healing, and positive change for the entire family system. Divided into two parts, the educational section offers insights into addiction as a chronic, progressive disease that hijacks the brain's reward system and impairs a loved one's self-awareness of their problem. The trauma chapters introduce readers to a continuum of traumas, including Post-traumatic Stress Disorder, Transgenerational Trauma, Complex/Developmental Trauma, and Secondary Trauma arising from living with a loved one struggling with addiction and trauma.

The second part of the book expands on resilience as both an individual and family process, exploring the dynamics of change, improving communication, and the path to family healing. These chapters provide practical steps empowering individual family members to effect positive changes that ripple into transformative shifts for the entire family. The book guides families in supporting their loved one's journey to recovery and reintegration into the family with full membership.

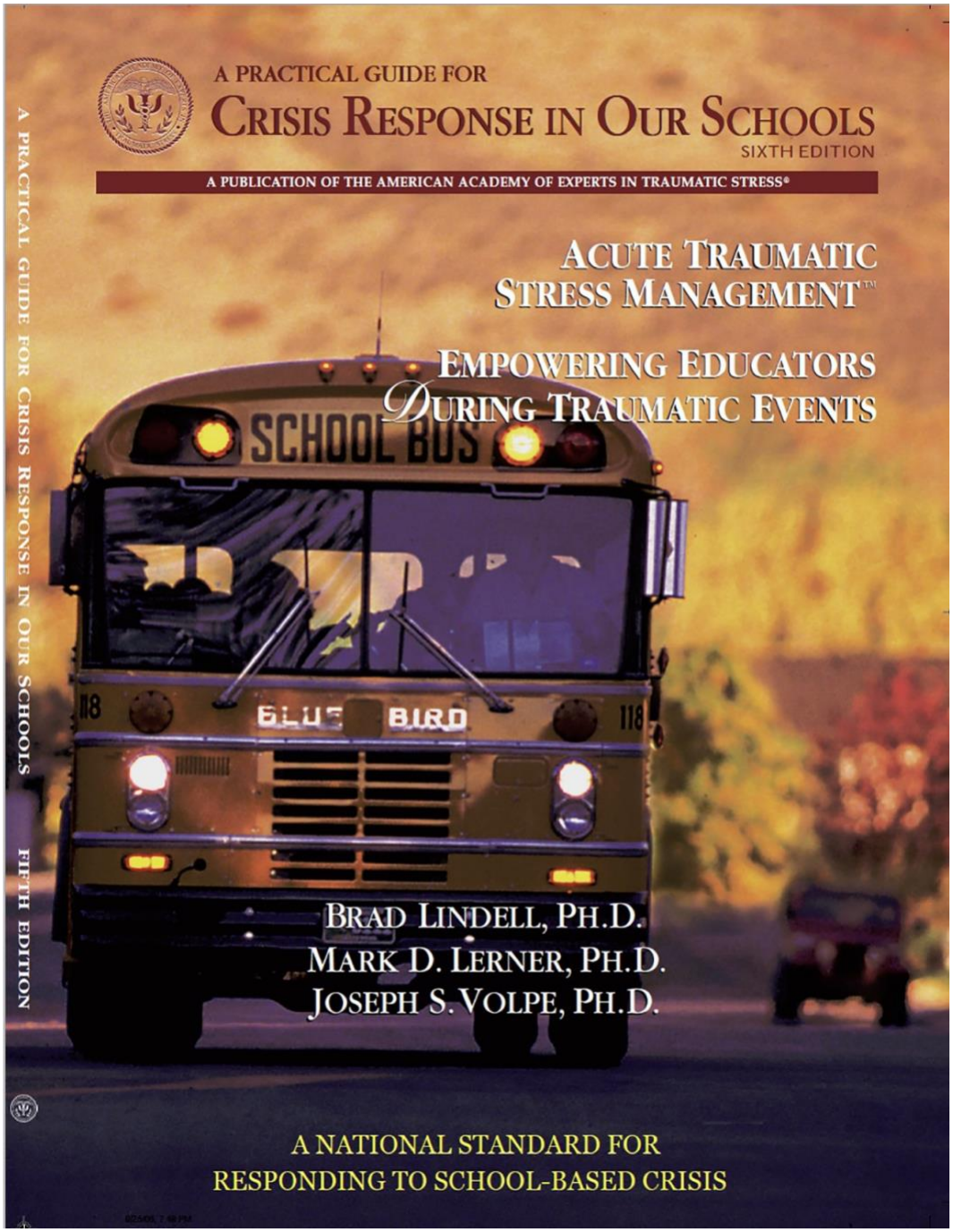
Ultimately, the book aims to guide families away from the perspective of "we are a family with a loved one who struggles with addiction" towards embracing the identity of "we are a family in recovery from addiction and trauma." By fostering understanding, empathy, and actionable guidance, this book seeks to empower families to break free from the cycle of addiction and trauma, promoting healing and a renewed sense of togetherness.

CLICK HERE TO ORDER THIS BOOK

PRACTICAL DOCUMENTS FROM

A PRACTICAL GUIDE FOR CRISIS RESPONSE IN OUR SCHOOLS

PUBLISHED BY THE AMERICAN ACADEMY OF EXPERTS IN TRAUMATIC STRESS



CLICK HERE FOR MORE INFORMATION

RESOURCES FOR DEALING WITH TRAUMATIC EVENTS IN SCHOOLS

NATIONAL CENTER FOR SCHOOL MENTAL HEALTH

The **National Child Traumatic Stress Network (NCTSN)** has a wealth of resources to assist caregivers and educators with how to best talk to and support students following traumatic events such as school shootings. **Click on the title to view the article.**

FOR EDUCATORS

- **Responding to a Mass Casualty Event at a School: General Guidance for the First Stage of Recovery**
- **Guidelines for Responding to the Death of a Student or School Staff**
- **Sample Letter Templates (Death of student, staff)**
- **Creating, Supporting and Sustaining Trauma-Informed Schools**
- **Providing Psychological First Aid: Principals and Administrators**
- **Creating Effective Child and Family Focused Disaster Behavioral Health Messages on Social Media**
- **School Crisis Guide**
- **The NASSP Principal Recovery Network Guide to Recovery**
- **Leading Through Crises**

SUPPORTING STUDENTS

- **Returning to School After A Crisis: A Guide to Addressing Traumatic Events at School**
- **Federal Resources for Helping Youth Cope after a School Shooting**
- **Childhood Traumatic Grief: Information for School Personnel**
- **Tips for Helping Students Recovering from Traumatic Events**
- **Talking to Children about Violence: Tips for Parents and Teachers (English)**
- **Talking to Children about Violence: Tips for Parents and Teachers (Spanish)**
- **Providing Psychological First Aid: Teachers**
- **Helping Youth After Community Trauma: Tips for Educators**
- **Suggestions for Educators: Helping a Traumatized Children in School**
- **Childhood Traumatic Grief: Information for School Personnel**
- **Systematic Review: Post-Crisis Interventions**

SELF CARE

- **Understanding Compassion Fatigue**
- **Compassion Resilience for School Leaders and Staff**

FOR YOUTH

- **When Terrible Things Happen: For Students**
- **Childhood Traumatic Grief: Youth Information Sheet**
- **Draw your Feelings**
- **For Teens: Coping After Mass Violence**
- **How to Cope with Traumatic Events**
- **Helping Kids Grieve: Feelings Journal Worksheet**
- **Taking Care of Yourself During and After a Disaster Crisis**

FOR CAREGIVERS

TALKING WITH YOUR CHILDREN

- **Talking to Children about Violence: Tips for Parents and Teachers**
- **Talking to Children about Violence: Tips for Parents and Teachers (Spanish)**
- **How Children Understand Death and What you Should Say**
- **Talking with Children about Tragic Events**
- **Guiding Adults in Talking to Children About Death and Attending Services**
- **Guidelines for Talking to Children about Terrorist Attacks and School and Community Shootings in the News**

TRAUMA/GRIEF RESPONSES IN CHILDREN

- **Age Related Reactions to a Traumatic Event**

HELPING CHILDREN COPE

- **After a Loved One Dies- How Children Grieve and Parents and other Adults Can Support Them**
- **Helping Young Children with Traumatic Grief: Tips for Caregivers**
- **Helping School-Age Children with Traumatic Grief: Tips for Caregivers**
- **Helping Teens with Traumatic Grief: Tips for Caregivers**
- **Tips for Survivors of a Disaster or other Traumatic Event: Managing Stress**
- **Helping Children Cope with Tragedy Related Anxiety**
- **Helping Children and Adolescents Cope with Disasters and Other Traumatic Events**
- **Tips for Helping Students Recovering from Traumatic Events**
- **Helping Children Cope with Trauma**
- **How to Cope with Traumatic Events**
- **Childhood Grief: When to Seek Additional Help**
- **Helping Your Children Manage Distress in the Aftermath of a Shooting**
- **Helping Children and Adolescents Cope with Traumatic Events**

SELF-CARE FOR CAREGIVERS

- **Compassion Resilience Toolkit for Parents and Caregivers**

FOR MENTAL HEALTH PROFESSIONALS

SUPPORTING STUDENTS

- **Psychological First Aid for Schools: Field Operations Guide**
- **Childhood Traumatic Grief: Information for Mental Health Providers**
- **Tips for Helping Students Recovering from Traumatic Events**
- **Helping Children Cope with Trauma**
- **Skills for Psychological Recovery: Field Operations Guide (*must be administered by a mental health professional)**
- **Culturally Competent Crisis Response**

SELF-CARE

- **Understanding Compassion Fatigue**
- **Compassion Resilience for School Leaders and Staff**

ADDITIONAL RESOURCES

- **American Academy of Pediatrics**
- **American Psychological Association**
- **Child Mind Institute**
- **Dougy Center**
- **Mental Health America**
- **National Association of School Psychologists**
- **National Association of of Sectionary School Principals**
- **National Center for School Crisis and Bereavement**
- **National Center for School Safety**
- **National Education Association**
- **National Institute of Mental Health**
- **New York Life Foundation**
- **PBS Kids**
- **Sesame Workshop**
- **Substance Abuse and Mental Health Services Administration SAMHSA**
- **The Jed Foundation**
- **The National Child Traumatic Stress Network**
- **U.S. Department of Education**
- **Wise**
- **Youth.gov**

Source https://www.nc2s.org/trainings-resources/crisis-navigation-resources/school-crisis-resources/

MANUSCRIPT GUIDELINES FOR THE
JOURNAL OF THE AMERICAN ACADEMY OF EXPERTS IN TRAUMATIC STRESS

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Preparation of Manuscripts

Authors are required to submit manuscripts via email (manuscripts@aaets.org) in Word format. The written material must be double-spaced, on single sided paper that is 8.5 by 11 inches. There must be one-inch margins. Pages must be numbered consecutively. Tables and figures should be numbered consecutively. Tables and figures will be placed near their first mention in the text. Reference must be made to the tables and figures in the manuscript.

Title Page

The following elements must be included:

- Title of the article;
- Name(s) and initial(s) of author(s), preferably with first names spelled out;
- Affiliation(s) of author(s);

Abstract

Each article is to be preceded by a succinct abstract, of up to 250 words, that highlights the objectives, methods, results, and conclusions of the paper.

Key Words

The author(s) should supply five to 10 keywords that identify the article.

References

In the text, references to the literature should be by author and year; where there are two authors, both should be named; with three or more only the first author's name plus "et al." need be given. The list at the end of the paper should include only works mentioned in the text and should be arranged alphabetically by name of first author. References should be cited as follows:

Journal papers
Name(s) and initial(s) of author(s), year in brackets, full title, name of the journal as abbreviated in Chemical Abstracts, volume number, first and last page numbers

Example: Lindell, B. (2010) Variability in response style as a function of interview method and impression management. Dissertation Abstracts 265:785

Books
Name(s) of author(s), year in brackets, full title, edition, publishers, place of publication, page number:

Example: Lindell, B., Lerner, M., Volpe, J. (2012) A practical guide for crisis response in our schools, American Academy of Experts in Traumatic Stress, New York

The responsibility for the accuracy of bibliography references is with the author(s). The American Academy of Experts in Traumatic Stress bears no responsibility for inaccuracies in references caused by the author(s).

AMERICAN ACADEMY OF EXPERTS IN TRAUMATIC STRESS
NATIONAL CENTER FOR CRISIS MANAGEMENT

APPLICATION FOR THE

AMERICAN ACADEMY OF EXPERTS IN TRAUMATIC STRESS
SCHOLARSHIP PROGRAM

AMERICAN ACADEMY OF EXPERTS IN TRAUMATIC STRESS
NATIONAL CENTER FOR CRISIS MANAGEMENT
127 ECHO AVENUE ● MILLER PLACE, NY 11764 ● 800-810-7550 ● 631-543-2217

APPLICATION FOR THE ACADEMY SCHOLARSHIP PROGRAM

THE AMERICAN ACADEMY OF EXPERTS IN TRAUMATIC STRESS®
THE NATIONAL CENTER FOR CRISIS MANAGEMENT®

The American Academy of Experts in Traumatic Stress, in collaboration with the National Center for Crisis Management, is proud to announce a Scholarship Program for members of our organizations and their immediate families who are in the process of or planning to obtain education and/or training in the areas of traumatic stress or crisis management.

The program will begin offering yearly scholarships of between $200 and $500 to individuals who meet the criteria set forth below. All applications being of equal quality, the first individuals to submit applications will receive priority. The scholarships will be awarded upon a winner providing proof of enrollment and payment for the education/training.

- Be a current member of the American Academy of Experts in Traumatic Stress or an immediate family member of a current member.
- Currently receiving education and/or training in traumatic stress or crisis management; or planning to become enrolled in said training.
- Currently attending an accredited institution or educational/training programs offering CEU's accredited by a recognized organization (e.g., Critical Incident Stress Foundation, American Psychological Association, etc.) or planning to become enrolled. The Academy reserves the right, after a review, to award scholarships to individuals attending educational/training programs that do not meet the above criteria.
- Provide proof of enrollment and payment in an eligible program.
- If under the age of 18, applicant must have a parent or guardian co-sign the application.
- Must demonstrate a history of success in the educational or training environments.
- Complete the Academy's application for the Scholarship Program and provide the required documentation.
- Submit the completed application to the Academy by the stated due date.

I. PERSONAL INFORMATION

FIRST NAME MIDDLE NAME LAST NAME

ADDRESS CITY STATE/PROVINCE COUNTRY ZIP CODE

WORK PHONE NUMBER EMAIL ADDRESS

PLEASE INDICATE THE FAMILY MEMBER WHO IS A MEMBER OF THE ACADEMY (ENTER 'SELF' IF YOU ARE THE MEMBER).

II. PROFESSIONAL/ETHICAL/LEGAL INFORMATION

	YES	NO
Have you ever been convicted of a felony?	❒	❒
Have you ever been disciplined for any type of unethical or illegal conduct?	❒	❒
Has your professional license/certification ever been revoked, suspended or limited?	❒	❒
Is there action pending related to your professional practice?	❒	❒
Is there action pending to revoke or limit your professional license/certification?	❒	❒
Have you ever voluntarily surrendered your license/certification?	❒	❒
Do you abuse alcohol or other substances?	❒	❒
Have you ever been denied professional liability insurance?	❒	❒

If you answered yes to any of the questions in Section II, please provide additional information for consideration with your application in the space provided below (use additional paper as needed).

III. EDUCATIONAL/TRAINING PROGRAM INFORMATION

Please indicate the name of the educational/training program.

_____

Please indicate the name of the organization or institution that is providing the educational/training program.

_____

Please indicate the type of educational/training program (e.g., workshop/seminar, college/university, formal training program).

_____

Please indicate the format of the program (e.g., online course(s), in-person, Zoom) _____

Please indicate the length of the program in total hours. _____

How many CEU's would you receive as a result of participating in the educational/training program? _____

Please provide the website address for the educational/training program. _____

IV. PERSONAL STATEMENT

Please indicate what contributions you have made to the field of traumatic stress and/or crisis management. If you do not yet have experience, how do you see yourself contributing to these fields in the future. Please also indicate why you were drawn to the areas of traumatic stress and/or crisis management (use additional paper as needed).

.

V. PROFESSIONAL BENEFITS OF EDUCATIONAL/TRAINING PROGRAM

Please indicate how the educational/training program will benefit you when engaging in professional activities within the areas of traumatic stress and/or crisis management (use additional paper as needed).

VI. DECLARATION

I hereby certify that all the information provided in this Application for Scholarship from the American Academy of Experts in Traumatic Stress is accurate and complete. I understand that my application will be reviewed by members of the Executive Board and the decision from the Executive Board regarding my application is final. I also understand that if more applications than scholarships are submitted and candidates are of equal quality, preference will be given to the applications that were submitted earliest. I agree to hold harmless the American Academy of Experts in Traumatic Stress and the National Center for Crisis Management, its officers and employees for decisions made on my application.

_____ _____

SIGNATURE DATE

_____

PRINT NAME

If applicant is under the age of 18, a parent/guardian's signature is required.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

_____

PRINT NAME

MAIL TO:
American Academy of Experts in Traumatic Stress
127 Echo Avenue, Miller Place, NY 11764

EMAIL TO:
scholarships@aaets.org

QUESTIONS:
Contact Annmarie Arleo at:
aarleo@aaets.org

AMERICAN ACADEMY OF EXPERTS IN TRAUMATIC STRESS
NATIONAL CENTER FOR CRISIS MANAGEMENT
127 ECHO AVENUE ● MILLER PLACE, NY 11764