# RESILIENCE IN TRAUMA AND DISASTER STEPHEN REGEL pdf

## 1: Resilience in trauma and disaster - Oxford Scholarship

*Keywords: resilience, trauma, disaster, psychosocial support, palliative care, human capacity, social ecology, culture, values Oxford Scholarship Online requires a subscription or purchase to access the full text of books within the service.*

This includes both the moral and legal duties to consider the psychological needs of personnel following exposure to traumatic events related to the workplace. While this has been recognized within many high-risk occupations such the police, fire and rescue services and the military, there is also evidence that post-trauma support in the workplace is increasingly commonly provided not only among health and social services agencies, but within many private sector organizations. Over the past decade, however, there has been considerable controversy over the provision of early psychological support to personnel in the form of critical incident stress management CISM processes. In particular, one aspect of CISM, the use of psychological debriefing PD has come under scrutiny and criticism as two studies indicated that PD was ineffective and had the potential to do harm. Inevitably, this has provoked much uncertainty and confusion among some organizations as what should be the most appropriate support. Despite the controversy, both CISM and PD continue to be provided on a widespread basis, often utilizing a framework of voluntary peer group support. This paper intends to i present a review of the current status of CISM practices, including the use of PD within various organizations in the UK and ii provide a clear framework and understanding of the main issues and to clarify conceptual misunderstandings. The history, principles and background of the use of post-trauma support in the workplace, charting trends over the past two decades, previous research, problems with the evidence base and current thinking and practice in the field are reviewed. The relevance and implications of the National Institute for Clinical Excellence Guidelines on the Assessment and Management of Post Traumatic Stress Disorder, which make recommendations for early interventions for post-traumatic stress disorder are discussed. Reference is made to the use of CISM and PD within both statutory and voluntary organizations in an international context. Peer group , post-traumatic stress , psychological debriefing , workplace support Introduction Critical incident stress management CISM was originally conceived and devised in the early s for the emergency medical services personnel in the US [ 1 ]. It has further developed and refined [ 2 , 3 ] over the past two decades and has since been clearly articulated in a comprehensive review [ 4 ]. CISM refers to a comprehensive, systematic and integrated multi-component crisis intervention package that enables individuals and groups to receive assessment of need, practical support and follow-up following exposure to traumatic events in the workplace. In addition, it facilitates the early detection and treatment of post-trauma reactions and other psychological sequelae. The basic conceptual framework was drawn from crisis intervention theories, a significant influencing factor was work developed by Lindemann following support offered to victims of the Coconut Grove nightclub fire in Boston, Massachusetts in [ 5 ]. This work was further developed and broadened by Caplan [ 6 ], from loss and grief to that of more broadly defined potentially stressful or traumatic events. CISM in its current form was designed to be used with groups of emergency personnel exposed to potentially traumatic experiences through the course of their work. CISM programmes comprise many elements, including pre-crisis education, assessment, defusing, critical incident stress debriefing CISD and specialist follow-up for ongoing psychological support if necessary [ 1â€”4 ]. This one aspect of the CISM process became the focus of attention for research because it was erroneously perceived that this particular aspect of the model would i prevent the development of post-traumatic stress disorder PTSD per se and ii was a stand alone process. The term PD was adopted by Dyregrov [ 8 ], a Norwegian psychologist who had also been using an almost identical structure since and always maintained that it is in essence the same as CISD. Since then the terms especially in Europe have become interchangeable and mean the same thing. The main difference apart from the names of some of the phases is that Dyregrov [ 8 ] places more emphasis on process than does Mitchell [ 1 ]. The latter has also been developed within a European context and therefore reflects a different tradition for groups and structure than in the US. PD represents a structured form of group crisis intervention and a discussion and review of the traumatic event or critical incident. The most common current model of PD is facilitated through a series of seven phases see

Figure 1. Dyregrov defined PD as: The seven stage model of Psychological Debriefing. View large Download slide The seven stage model of Psychological Debriefing. PD typically takes 1. The aim of PD is also to provide education about normal and pathological reactions to traumatic events, indicate resources for further help and support if necessary and to begin to facilitate the process of coming to terms with the traumatic incident. Most importantly, it was designed to facilitate early help seeking. It also aims to facilitate normal recovery, resilience and personal growth. PD as reviewed by the Cochrane Reviews [ 9 ] has been consistently and misleadingly viewed as a form of counselling or psychotherapy. PD is based on crisis intervention theory and is psycho-educational in purpose, rather than concerned with the re-configuration of personality or altering personal defences as is the case with counselling and psychotherapy. Inevitably, and equally importantly, this also influences the thinking behind the development of policy in terms of support mechanisms within the context of health and safety and occupational health and welfare provision. Therefore, the whole principle and ethos behind CISM has become negatively influenced and driven by the focus on one aspect of a programme, for reasons which have never been clearly understood. The research In , an editorial was published in the British Journal of Psychiatry which reviewed some existing studies on PD [ 10 ]. The conclusion was that more research was needed as there were a number of significant methodological shortcomings in the studies undertaken. These were highlighted as follows: Of particular note here is the issue of lack of uniformity. This is of particular significance as it is a key element of the research and has been cited by the National Institute for Health and Excellence NICE clinical guidelines [ 11 ] and will be addressed in more detail below. Two randomised controlled trials RCTs were subsequently published. Both studies were carried out with primary victims of trauma, i. Both studies demonstrated negative effects among the intervention groups. The Cochrane report on PD [ 9 ] has been interpreted as providing evidence that PD could have negative effects on people and this resulted in many organizations and professionals abolishing PD as an organizational response. However, there are a number of reasons why this conclusion should be approached cautiously. First, the studies reviewed by Cochrane [ 9 ] consisted only of RCTs of single sessions with individuals who were primary victims of trauma, as described above. Second, there were a number of methodological shortcomings in the two most cited studies [ 11 , 12 ]. In the study on burn trauma [ 11 ], the authors acknowledged that the vagaries of randomization meant that all the subjects with the highest levels of subjective life threat, previous psychological morbidity and previous psychological treatment, all factors predictive of poor psychological outcome, were in the intervention group. Imaginal exposure is a psychological treatment technique, which is often used with trauma survivors as part of a comprehensive psychological treatment package. It is a technique that involves the patient reliving the traumatic experience as if it were occurring again, describing their experience in the first person and in the present tense. It is a demanding and anxiety provoking procedure, which is only conducted after careful assessment and consent of the patient within the confines of an established therapeutic relationship. PD, as described above, does not entail imaginal exposure. The study involving road accident victims [ 13 ] was also not without limitations. The authors in a later volume describing the study in detail acknowledged that. Furthermore, the two studies just mentioned failed to achieve equivalent group membership at pre-test debriefed groups had more severe injuries in both studies. These differences may well have influenced post-intervention outcomes. Moreover, the deterioration in the psychopathology of the debriefed group in the road accident study, although statistically significant, was so slight as to be clinically irrelevant [ 13 ]. Therefore, the two most quoted studies that cast doubts on the efficacy of debriefing are methodologically flawed and thus cannot be seen as representative of research in this field. Thirdly, the Cochrane Review [ 9 ], which was also used as the criteria for inclusion in the NICE guidelines [ 11 ], acknowledged that there was a lack of or inappropriate training for those facilitating PD as it is defined above. There are no detailed descriptions of training described in any of the RCTs reviewed through the Cochrane process. Symptomatology of PTSD was generally employed as the main outcome measure, and none of the studies assessed the impact of the intervention on other symptoms of trauma, e. Those studies that have measured a broad range of outcomes and which were conducted with groups have demonstrated a positive debriefing effect [ 15â€”18 ]. For these reasons, the conclusion to the Cochrane report must be approached cautiously as many of the studies included in the review were not concerned with CISM or PD

procedures as they are technically defined by workers in that field. It is also often suggested that PD is of little benefit for those suffering from PTSD, which is of course true, as it was never intended for PTSD sufferers, given that it is intended as a crisis intervention strategy used within the first 2 weeks following exposure to an incident. PTSD can only be diagnosed 1 month after exposure to the traumatic event. An example is critical incident processing [ 22 ], which contains all the elements recommended by Everly and Mitchell [ 4 ] and thus CISM by another name. TRiM has been described as a post-traumatic management strategy based upon peer group assessment for hierarchical organizations [ 24 ]. On close inspection, models which purport to be offering different solutions to post-trauma support are all seen to be practising CISM and PD under new acronyms. While TRiM can be seen to be very effective in a military context, it remains to be seen whether it is transferable to other contexts and settings, even though some UK police forces have adopted the model. The authors argue that the focus on risk assessment avoids excessive exploration of emotions or enforced catharsis, which they claim is the case with PD. They also suggest that this is in keeping with the conclusions of the Cochrane review that suggests that the exploration of emotions may in part be responsible for the worsening of symptoms [ 24 ]. Enforced catharsis was never the aim of PD, as those who have been trained and are experienced in the model as devised by Mitchell and Dyregrov would know that this was not the intended aim of the structure and process. The evidence suggests that worsening of symptoms and reactions may be due to the inappropriateness of the application of the model and the lack of training in PD which may account for the negative outcomes. That is, it is akin to assessing a surgical technique as having a poor outcome, but only researching its effectiveness after it has been used in inappropriate circumstances, with the wrong instruments, untrained practitioners and with the wrong patients. Another criticism aimed at PD is that it is compulsory in many organizations [ 25 ]. This is inaccurate, particularly in public sector organizations in the UK. The vast majority of organizations if not all within the public sector that offer PD within the context of a CISM programme, do so on a voluntary basis. This includes fire and rescue services, health and social care providers and the police. In many instances this is a combination of welfare and operational personnel. The same may not apply to the private sector, which utilizes the services of Employee Assistance Providers EAPs for counselling and post-trauma support needs. EAPs also offer PD and other related services, but these services can be more difficult to quality control in real terms within an organizational context and setting where CISM programmes work most effectively. An important part of the brief was to look at the existing research. Another conclusion was that if PD was to be successful, it had to be undertaken by competent practitioners within an appropriate context and setting, with adequate supervision and support. Much of the evidence cited in the guidelines is drawn from the Cochrane review and therefore cites the same studies as described above. Nevertheless, there is a wealth of literature supporting the use of PD in these settings [ 15â€”18 ]. However, as none of these are randomized control trials they did not merit inclusion in any of the literature reviews. RCTs appear to have become the dominant paradigm of treatment outcome studies to the virtual exclusion of naturalistic, observational studies or case series evidence levels iiâ€”v. The Guidelines state that they do not recommend systematic brief single-session interventions focused on a traumatic incident. This is again based on the RCTs on PD with negative outcomes which have all focused on individuals who have been primary victims, but the Guidelines offer little practical guidance to many occupational health and welfare departments who may have to see individuals affected by potentially traumatic events within the workplace. The reality is that if individuals are seen after the incident, it is not compulsory, but a mutually consensual arrangement. It is never brief or for a single session, as follow-up is always offered. Finally, the clinical practice recommendations with the Guidelines indicate that â€¦ we do recommend the good practice of providing general practical and social support and guidance to anyone following a traumatic incident. Support and guidance are likely to cover reassurance about immediate distress, information about the likely course of symptoms, and practical and emotional support in the first month after the incident [ 11 , p. Most significantly, there is nothing in the Guidelines to suggest what should be done in order to fulfil that recommendation or address these issues. Therefore, what is clear is that many organizations are continuing to offer both individual and group support for personnel involved in potentially traumatic events in the workplace through a CISM programme as it is clear this meets the requirements suggested as exemplified by the recommendation

described above. These organizations continue to provide PD as part of that programme. Those organizations who have scrutinized the recommendations of the NICE Guidelines thoroughly and are aware of the history, developments and controversy surrounding PD, realize and understand that they are operating within the scope of guidelines and are thus mindful of fulfilling their duty of care to personnel who work in challenging and difficult environments. In a review of the existing evidence, it has been demonstrated that the studies have considerable methodological shortcomings, particularly utilizing PD, and crisis intervention techniques designed for groups of emergency service personnel with primary victims of burn trauma and accidental injury.

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## 2: Defining Trauma and Resilience Conference â€“ April , â€“ SERD Antioch University New England

*Regel, S () Resilience in Trauma and Disaster (Chapter 13, pp ) In: Monroe, B and Olivere, D (Eds) Resilience in Palliative Care - Achievement in Adversity, Oxford University Press, Oxford.*

Professor of Psychiatry, Post-Traumatic Stress Disorder, and Resilience, Yale Medical School The Science of Resilience When my colleagues and I began to study post-traumatic stress disorder, we assumed resilient people were somehow special, perhaps genetically gifted. Everyone can learn and train to be more resilient. Some individuals were clearly more resilient than others. The American Psychological Association defines resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of threat. In our book, Resilience: Because resilience is the complex product of genetic, psychological, biological, social and spiritual factors, we investigate resilience from multiple scientific perspectives. We synthesize the latest scientific and popular literature on the topic, describe our own psychological and neurobiological research on resilience, and quote from our in-depth interviews with a large number of highly resilient people. When we began our study, we assumed that resilience was rare and resilient people were somehow special, perhaps genetically gifted. It turns out, we were wrong. Resilience is common and can be witnessed all around us. Even better, we learned that everyone can learn and train to be more resilient. The key involves knowing how to harness stress and use it to our advantage. After all, stress is necessary for growth. Without it the mind and body weaken and atrophy. While no one gene or gene variation explains resilience, genetic factors do play an important role in determining how an individual responds to stress and trauma. For example, DNA studies have found that polymorphisms i. This means that genes are important but that they are only part of the story. A host of neurobiological factors and systems have been associated with resilience including a sympathetic nervous system i. Emerging scientific research has begun to show that neurobiological systems associated with resilience can be strengthened to respond more adaptively to stress. For example, research using EEG and fMRI technology has shown that mindfulness meditation and training in cognitive reappraisal can increase activation of the left prefrontal cortex. This is important because people with greater activation of the left prefrontal cortex recover more rapidly from negative emotions such as anger, disgust, and fear. University of Wisconsin researcher Richard Davidson has proposed that resilience is largely related to activation of the left prefrontal cortex and the strength of neural connections between the prefrontal cortex and the amygdala. Robust activation of the PFC inhibits the amygdala, quiets associated anxiety and fear-based emotions, and allows the PFC to facilitate rational planning and behavior. As a second example, the hippocampus is another brain region that is critically involved in resilience and how we respond to stress. It is well known that unremitting stress with prolonged elevation of cortisol can damage neurons in the hippocampus. Because the hippocampus helps to regulate the hypothalamic-pituitary-adrenal axis, damage to its neurons can decrease their ability to dampen the stress response. The result may be even greater damage to hippocampal neurons. Fortunately, recent research has found that nerve growth factors, like brain-derived neurotrophic factor, enhance the growth of brain cells, prolong cell survival, and repair damaged nerve cells. In animal studies, vigorous voluntary aerobic exercise increases levels of nerve growth factor and appears to protect against some of the negative effects of stress. This may also be true in humans where research has shown that aerobic exercise can increase hippocampal volume, raise serum levels of BDNF, and improve spatial memory, and that physically active subjects show lower cortisol and SNS responses to psychological laboratory stress compared to less physically active subjects. As scientists learn more about the complex interplay of genetics, development, cognition, environment, and neurobiology, it will be possible to develop behavioral, social and pharmacological interventions and training programs to enhance resilience to stress. Southwick, MD, a recognized expert on the psychological and neurobiological effects of extreme psychological trauma, is the co-author of Resilience: For more information about Dr.

# RESILIENCE IN TRAUMA AND DISASTER STEPHEN REGEL pdf

## 3: Stephen Joseph - The University of Nottingham

*This chapter examines resilience in relation to trauma and disaster. The past decade has seen an increasing focus and consensus on the importance of providing psychosocial support following.*

Building bridges between positive psychology and person-centred psychotherapy 2nd. Positive psychology in practice: Promoting human flourishing in work, health, education, and everyday life 2nd. Applied positive psychology 10 years on. Promoting human flourishing in work, health, education, and everyday life Wiley. The future of positive psychology in practice. Promoting human flourishing in work, health, education, and everyday life 2nd edition. Expressive writing and posttraumatic growth: An internet-based study Traumatology. Theory, Research and Practice. Understanding posttraumatic stress and facilitating posttraumatic growth. Relationship-based social work and its compatibility with the person-centred approach: Trauma and the therapeutic relationship: Person-centered approach, positive psychology and relational helping: Building bridges Journal of Humanistic Psychology. Psychosis within dimensional categorical models of mental illness Psychosis. Facilitating posttraumatic growth through relational depth. New perspectives and developments Palgrave. The Structure of Avoidance Following Trauma: Putting the relationship at the heart of trauma therapy. Approaches to Process and Practice Palgrave, Macmillan. Affective-cognitive processing and posttraumatic growth. Reflections and directions for future research and practice. Working with traumatized clients and clients in crisis. The Handbook of person-centred psychotherapy and counselling Palgrave. Theory, Practice and Research Springer. An affective-cognitive processing model of posttraumatic growth Clinical Psychology and Psychotherapy. Preliminary development of a measure of responses following adverse humanitarian Aid work Traumatology. Theory, Research, Practice, and Policy. Development of an evidence based tool Mental Health Review. Psychological growth in humanitarian Aid personnel: Reintegrating with family and community following exposure to war and genocide Community, work and Family. Mutuality in person-centered therapy: A new agenda for research and practice Person-Centered and Experiential Psychotherapies. Treating traumatic memories in Rwanda with the Rewind Technique: Two-week follow-up after a single group session Traumatology. Short form of the changes in Outlook Questionnaire: Cognitive processing, rumination, and posttraumatic growth Journal of Traumatic Stress. The Impact Of Injuries Study. Journal Of Traumatic Stress. Religiosity and posttraumatic growth: Meaning in life and posttraumatic growth Journal of Loss and Trauma. An interpretative phenomenological analysis of posttraumatic growth in adults bereaved by suicide Journal of Loss and Trauma. Countertransference and positive growth in social workers Journal of Social work Practice: Psychotherapeutic approaches in Health, Welfare and the Community. What to expect when being counselled for post-traumatic stress Lutterworth: British Association for Counselling and Psychotherapy. International Conference on Traumatic Stress. Does the CES-D measure a continuum from depression to happiness? Comparing substantive and artifactual models Psychiatry Research. Theories of counselling and Psychotherapy: An introduction to the different approaches Palgrave. The absence of positive psychological eudemonic well-being as a risk factor for depression: A ten year cohort study Journal of Affective Disorders. Theories of Posttraumatic Growth: Letter to the Editor. An agenda for the next decade of psychotherapy research and practice Psychological Medicine. The facts Oxford University Press. Vicarious Posttraumatic Growth Among Interpreters. Psychological mindedness and therapist attributes Counselling and Psychotherapy Research. Working with psychological trauma Healthcare Counselling and Psychotherapy Journal. Vicarious growth in wives of Vietnam veterans: A post-medicalised vision for positive transformation. Qualitative Research in Mental Health: Assessment of caring and its effects in young people: Growth following adversity and its relation with subjective well-being and psychological well-being Journal of Loss and Trauma. Gratitude predicts psychological well-being above the big five facets Personality and Individual Differences. The person-centred approach to coaching. Statistics in counselling and psychotherapy. The diversity of trauma research: Sustaining a positive altruistic identity in humanitarian Aid work: A qualitative case study Traumatology. Development and delivery of a physiotherapy intervention for the early management of

whiplash injuries: Positive psychological perspectives on posttraumatic stress Psychological Topics. Gratitude influences sleep through the mechanism of pre-sleep cognitions Journal of Psychosomatic Research. A guide for practitioners Routledge. Trauma, recovery, and growth: Conceptualizing gratitude and appreciation as a unitary personality trait Personality and Individual Differences. Positive psychology as a framework for practice. A textbook for trainees and practitioners JKP.

# RESILIENCE IN TRAUMA AND DISASTER STEPHEN REGEL pdf

## 4: Resilience in Palliative Care: Achievement in adversity - Oxford Scholarship

*Post-traumatic stress disorder (PTSD) is an anxiety disorder that can develop after exposure to one or more traumatic events. It is a severe and ongoing emotional reaction to extreme psychological trauma, such as threat to life, being a victim of crime or sexual assault, witnessing someone's death, or a threat to one's physical and/or psychological integrity.*

He spent 10 days trapped in a flooded Mexican cave in , before being rescued by Rick Stanton , the British cave diver who found the boys in Thailand last Monday. For the past fortnight, ever since he heard that the young football team and their coach had gone missing in a cave, Sims has been reliving the nightmare of his experience. I have been thinking about them a lot. Any physical injuries they have suffered should heal quickly, but the effects on their mental health could last far longer. Unlike the boys, Sims is an experienced cave diver and, as a former ammunition officer who served in Kosovo and the Falklands, is used to finding himself in difficult and dangerous situations. All through the night, we could hear the noises getting louder and louder. It made us feel We kept talking about what we were going to eat after we got rescued, to keep up our morale, and we told each other our life stories. I think what will keep those boys going is that they are in there with mates. The fact that the children were all together in one place, not alone, separated or injured; that they are a football team with a level of camaraderie, along with an adult who can keep them buoyed up, and reassure them: It means the children are less likely to develop psychological problems later on. But the longer they remain in there, the longer they may need to readjust when they get out. Twenty-six years after Les Hewitt was trapped overnight in Sleets Gill Cave in North Yorkshire by a flood, he still has dreams about being stuck in a room that is slowly filling with water. I was a grown man, and I was very frightened. Those children must have been terrified. I think it was the euphoria I felt when I was rescued. It was such an intense experience. But children are very resilient and will believe what adults tell them. It was probably an adventure to go into the cave, and I suspect the divers will turn the rescue into an adventure, too. The children will also undoubtedly feel reassured by the firm leadership and sense of authority the divers would have, as navy Seals. But the divers will be feeling the pressure. There will be concerns about the air supply and a build-up of CO2 in the cave.

# RESILIENCE IN TRAUMA AND DISASTER STEPHEN REGEL pdf

## 5: Resilience in Palliative Care - Barbara Monroe; David Oliviere - Oxford University Press

*Resilient organizations: part 2: organizational resilience within the National Health Service and cancer care / Timothy Jackson. Resilient communities / Allan Kellehear and Barbara Young. Resilience in trauma and disaster / Stephen Regel. Resilience in resource-poor settings / Amanda Bingley and Elizabeth McDermott.*

Specifically, her work aims to clarify the role of emotion dysregulation in the development and maintenance of PTSD, as well as explore whether maladaptive ways of responding to negative and positive emotions heighten involvement in risky behaviors among individuals with PTSD. Her research aims to better understand the influence of cultural and contextual factors, such as racial and ethnic minority status and gender, on the ways in which PTSD emotion dysregulation, and risky behaviors interact. Community Room, 1st Floor  Prior to his work with the DCF, Dr. Rayford served as the Director of Health, Mental Health and Addiction Services for the Connecticut Department of Correction, where he was responsible for program development and the management of treatment services for the population of 20, inmates. Kathryn Scheffel is a clinical psychologist with specialties in anxiety disorders, trauma, self-harm behaviors, parenting skills, and psychological assessment. For the past five years, Dr. Scheffel is a clinician at the Albert J. She treats youths, ages years, with complex issues and their families. She supervises psychology practicum students and co-leads an assessment seminar providing group supervision on testing cases. Scheffel treats adults and adolescents at her community private practice. Scheffel earned her Ph. Community Room, 1st Floor Lunch Option: Food Truck, Price Range: Ann Rosoff received her doctorate from the University of North Carolina at Chapel Hill in , and worked in partial hospitalization and psychiatric inpatient settings before entering private practice in  At present, she is a partner at the Green House Group, PA, in Manchester, where she works with adults and couples, and supervises other clinicians. Her approach to treatment integrates elements of attachment and developmental theory, research on trauma and resilience, and neurobiology. In her work with patients, she draws from a wide variety of treatment techniques that include psychodynamic, family and cognitive therapies, Internal Family Systems and Ego State work, hypnosis, mindfulness, and somatic experiencing. She has a special interest in treating complex trauma, and has submitted a paper for publication: How we do what we do: The therapist, EMDR, and the treatment of complex trauma. Ann began working with dissociation without knowing it many years ago, and is still learning. Community Room, 1st Floor 3: Lessons from a Decade of Struggle. Stephen Soldz is a psychologist, psychoanalyst, social activist, and researcher in Boston. His research has spanned the areas of psychotherapy process, personality, adult development, substance abuse policy, tobacco control, and program evaluation. For over a decade, Dr. Soldz has been in the forefront of efforts to withdraw psychologists from aiding abusive interrogations and end US torture. He published numerous professional articles, book chapters, and popular articles on U. Soldz was a consultant on several Guantanamo legal cases. Community Room, 1st Floor 4: Resilience in Disaster Response Workers: A Comparison of Two Trainee Samples. Judge for Prize-winning poster: Keynote Speaker Kari A. Resilience Processes in Cosmology Episodes. She has written several books, articles, and book chapters and presented at professional conferences on the topics of disasters, resilience and sense-making. She serves as the Multicultural and Diversity Issues chair of her department. She teaches Crisis Intervention, Research Methods, and Diversity Issues in counseling courses to masters and doctoral students. Community Room, 1st Floor Symposium. First Responder Mental Healthcare: Evidence-Based Prevention, Postvention, and Treatment. The Role of Psychosocial Mediators. She was the managing attorney in the Keene office, serving Cheshire and Sullivan counties for 24 years, retiring in  Her interests beyond litigation and defense of indigent defendants included developing alternatives to incarceration for those with mental health and substance use disorders.

## 6: The Science of Resilience | HuffPost

*Stephen Regel, Centre for Trauma, Resilience and Growth, Nottinghamshire Healthcare NHS Foundation Trust/School of Education, University of Nottingham, UK,Stephen Joseph, Centre for Trauma, Resilience and Growth, School of*

*Education, University of Nottingham/ Nottinghamshire Healthcare NHS Foundation Trust, UK.*

## 7: - NLM Catalog Result

*programme in Kosovo. He is the co-author (with Stephen Joseph), of a handbook on psychological trauma and post traumatic stress for Oxford University Press, The facts series, written for sufferers and families, but also for other professionals e.g. GPs, nurses, the emergency services, counsellors.*

## 8: Post-traumatic Stress - Stephen Regel; Stephen Joseph - Oxford University Press

*Trauma-focused cognitive behavioural therapy was the most common therapeutic treatment, but person-centred therapy was found to have increased in availability within specialist trauma services.*

## 9: Trapped: how survivors deal with trauma of cave ordeals | News | The Guardian

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