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Spotlight on Mental Health on a Healthcare Campus: An Assessment of Psychological Trauma Awareness, Training, and Treatment in the University of Nebraska Medical Center College of Public Health community

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An assessment of psychological trauma awareness, training, and treatment in the University of Nebraska Medical Center College of Public Health community

A Capstone Project in fulfillment of the MPH

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Abstract:

Background: Psychological trauma has been recognized as a public health concern of epidemic proportions globally. Public health community awareness of and education in trauma is likely to be integral to preparing future public health professionals to work effectively and safely in the field. Currently, the extent of trauma awareness, training, and treatment on the University of Nebraska Medical Center College of Public Health (UNMC COPH) campus is not known.

Aims: The aims of this project are to investigate and assess the level of psychological trauma awareness, training, and treatment on the UNMC COPH campus; and to provide recommendations for actions that will support the development of trauma awareness, education, and healing on campus.

Method: The Community Readiness Model (CRM) was used to guide the research. Nine participants from myriad sectors and across multiple levels of the college and university hierarchy were interviewed. Transcripts were scored according to the CRM and coded for thematic patterns.

Results: The UNMC COPH total Community Readiness score was found to be at stage 3 of 9: Vague Awareness. Community members were found to have a spectrum of knowledge about psychological trauma and generally considered it to be a problem. However, there was little awareness of what should be done to address it and few resources available. Higher readiness scores were found in the domain of Community Climate, lower scores were in the realms of availability of community resources and knowledge of resources for mental health. Themes regarding psychological safety, shame, the neoliberal milieu, conflation of diversity/inclusion work with trauma work, and paradigm shifts were revealed and are explored in the discussion.

Conclusions: The COPH could do much more to promote trauma awareness, integrate trauma education into the curriculum and campus life, and provide for evidence-based trauma treatment on campus. To do so will likely require a paradigmatic shift and the careful management of many changes in multiple parts of the community simultaneously or in concert.

Introduction

Psychological trauma has been recognized by multiple groups and studies as a public health concern of epidemic proportions (Chatterjee, 2019; Magruder et al., 2017; Mew et al., 2022; Rosenbaum, 2021). Recent research has revealed gaps in trauma education in medicine, psychology, research, and public health (Cook et al., 2017, 2019; Courtois & Gold, 2009; Drozdzewski & Dominey-Howes, 2015; Gowen et al., 2023; Harrison et al., 2020; Hughes et al., 2021; McAuliffe et al., 2019; Mengesha et al., 2022; Mocnik, 2020; Newell, 2017; Nikischer, 2019; Parker & Johnson-Lawrence, 2022).

Additionally, there are concerns about how trauma and its variable symptoms are discerned, tracked, and treated on university campuses, as well as whether mental health and trauma are being prioritized effectively, even in the healthcare professions (Artime et al., 2019; Center for American Progress, 2019; Cuijpers et al., 2019a, 2019b; Griffiths, 2022; Kang et al., 2021; Mocnik, 2020; Nikischer, 2019; Pihkala, 2020; Strauss, 2022). Ample evidence shows that trauma, and symptoms of trauma such as depression, anxiety, and substance abuse, are a serious and prevalent concern in the undergraduate and graduate populations (Almhdawi et al., 2018; Artime et al., 2019; Center for American Progress, 2019; Cook et al., 2017, 2019; Cuijpers et al., 2019a, 2019b; Cusack et al., 2019; Fedina,et al., 2016; Gowen et al., 2023; Hingson et al., 2016; Hughes et al., 2021; Kang et al., 2021; Karatekin, 2016; Mengesha et al., 2022; Talebkhah-St.Marie & Cook-Cottone, 2022). This is particularly true among women and other groups marginalized because of race, gender identity, and/or sexual orientation (Center for American Progress, 2019; Conron et al., 2022; Douglass, 2022; Fedina et al., 2016; Jones, 2020; Steinman & Kovats Sanchez, 2021).

Douglass (2022) asserts that “Post-traumatic Stress Disorder (PTSD) is an anxiety disorder, but *it is also a learning disorder* [emphasis added] that leads to inappropriate generalizations of past learning to new situations…and ‘deficits in verbal memory and executive functioning” (p.92). Trauma is composed of a unique cluster of mental and physiological symptoms that includes withdrawal/avoidance, hyperarousal, intrusive thoughts/memories, and cognitive restructuring of the self and worldview (Herman, 1992, 2023; Levine, 1997; Rothschild, 2000; Van der Kolk, 2014). Traumatic sequelae can inhibit learning, memory retention, organizational skills, and capacities for self-soothing essential to undertaking any academic endeavor, particularly in higher education and the health professions. The symptoms and coping mechanisms associated with trauma can also interfere with an individual’s ability to complete their degree and there is currently “a paucity of research” on how to help people with PTSD in this situation (Douglass, 2022, p.92).

Students in the health professions are particularly at risk of suffering mental health issues triggered by what can be chronically stressful educational and training regimens as well as by trauma they witness as a matter of course in their training and work (Almhdawi et al., 2018; Council on Medical Education, 2019; Courtois & Gold, 2009; Hughes et al., 2021; King et al., 2017; Lehrner & Yehuda, 2018; Matejko, 2022; McAuliffe et al., 2019; Mengesha et al., 2022; Mocnik, 2020; Nikischer, 2019; Parker & Johnson-Lawrence, 2022; Perry et al., 2023; Pihkala, 2020). Additionally, while not yet well substantiated, there is some evidence that people who experience more childhood trauma may preferentially choose to enter the health professions (King et al., 2017). It has also been shown that early childhood trauma puts individuals at higher risk of incurring future trauma and developing mental health problems (Artime et al., 2019; Benuto et al., 2018; Cukor et al.,

2009; Cusack et al., 2019; Karatekin, 2016; Lehrner & Yehuda, 2018; Newell, 2017; Pihkala, 2020; Rinfrette et al., 2021; Smith et al., 2022; Vrklevski & Franklin, 2008).

Considering the likely prevalence of trauma within the university landscape; the potential severity of trauma's impact within the campus community if unaddressed; the fact that contemporary university classrooms, current pedagogical practices, and professional training regimens have a tendency to trigger and exacerbate trauma, especially for certain populations; and the critical importance of preparing healthcare professionals to work knowledgeably and responsibly with traumatized people and in potentially traumatizing situations, it seems wise to explore how trauma is understood, learned about, and dealt with on the COPH campus.

The aims of this project have been twofold:

1. To investigate and assess the level of psychological trauma awareness, training, and treatment on the University of Nebraska Medical Center College of Public Health (UNMC COPH) campus;

and, based on strengths and gaps found,

2. To provide recommendations for actions toward short, mid, and long-term goals that will support and fortify the development of trauma awareness, education, and healing on campus.

To achieve these aims I interviewed nine individuals associated with multiple sectors within the College of Public Health (COPH) campus community using the Community Readiness Model as my guide (Tri-Ethnic Center for Prevention Research, 2014).

The process and results of this study are significant because they stimulate thought and discussion about psychological trauma where there may have been little; reveal blind spots or gaps in current mental health and trauma knowledge and practices on campus; and shine a light on resources and pathways that have the potential to enhance efforts to address trauma in the community in the future. Critically, because the COPH is concerned with preparing and mentoring prospective public health professionals, any enrichment or expansion of trauma education, recognition, and healing on campus will ultimately be integrated to serve individuals and populations around the world that future graduates work with.

Positionality Statement

As suggested by Savin-Baden & Major (2013), I think it is important to clarify my own stance with regard to this project in relation to three areas in particular:

1. The purpose and meaning of the project
2. Others who have participated in the project
3. The context of the project

First, I was inspired to pursue an investigation into this particular subject matter, i.e., psychological trauma on campus, because of my own recognition that I was experiencing vicarious trauma due to interactions with classroom materials. I was able to identify and contextualize the symptoms I was experiencing for three reasons that also have a bearing on this project:

- I have a fairly extensive background in psychology and trauma. This includes a one-year certificate in Transpersonal Psychology and eighteen months of a master's degree in counseling psychology.

- I am a survivor of trauma. While the trauma I have experienced is extremely minimal compared to the scope of what many beings endure and survive, I have been profoundly impacted by my experiences and they have shaped the course of my life in myriad and often unconscious ways.
- As an adult I have regularly used individual psychotherapy to explore and come to terms with my past, drag what has been unconscious into the light of awareness, and heal my relationships with self and others. This, in turn, has enabled me to expand and deepen as a being.

I take mental health and self-awareness seriously and place a high value on it. I also place a high value on societal and institutional support for mental health. I believe work, community, and educational spaces should be providing employees, citizens, and students not only access to clinical mental health professionals but should also be proactively making mental health care accessible in terms of time, space, and economics, as well as destigmatizing and creating a positive, knowledgeable context for it. I also believe that public health students, and in fact all students training to become health professionals, must have formal, foundational, explicit training in psychological trauma both for their own sakes and for the well-being of those with whom they will work—both colleagues and clients.

Second, I am a White, cisgender, heterosexual, married, highly educated woman socioeconomically in the top 5-10% globally. As will be described, the majority of those who agreed to be interviewed for this study are White. Altogether I reached out to seven People of Color and ten White people. Ultimately, one Person of Color chose to participate. In response to one email that was sent out from the Capstone office via Canvas asking for student participants, only one White person responded.

I will explore the lack of diversity in my sample population in more detail below. What is important for this statement is that my demographic identity has an impact on how I am interpreting the non-participation of People of Color in this project. Because of my education and my understanding of trauma, I am likely to consider the choice not to participate from a sympathetic point of view that acknowledges that participation in an inquiry involving psychological trauma within the campus community might feel more dangerous, fraught, or exhausting to a Person of Color than to a White person who might have similar or even more obvious demands on time and energy.

Third, my political leanings skew left of liberal into the progressive and socialist end of the spectrum. The infiltration of neoliberal economics, thought, and behavior into institutional settings globally and educational settings in particular is anathema to me. Particularly, I find the emphasis on the individual both destructively narcissistic and horrifyingly isolating, and recognize that the corresponding neglect of the communal is systematically undermining societal, global, and environmental well-being and inculcating rage, hatred, violence, desperation, and despair.

I have attempted to be conservative in analyzing the effects of neoliberalism on what I was hearing/reading in the data. While neoliberalism tends to have profound and far-reaching effects on our lives as individuals and societies, it is also, to a large extent, the sea in which we currently swim and so placing a lot of focus on it may not be helpful. Primarily, it is important to acknowledge its bearing on our thinking and behavior in order to make its workings conscious. In this way, we make ourselves freer to make choices in alignment with values that foster a world we aspire toward rather than paradigmatic values with which we are currently entangled and that perpetuate ways of being we wish to release.

In the course of this study, I found evidence that neoliberal philosophies and practices may be a contributing factor in the scarcity of mental health resources generally on campus; the tendency to address traumatic situations that arise more *re*actively than *pro*actively, and privately; and the fact that there are *no* efforts to address trauma specifically and directly on campus and very little explicit education about trauma in the classroom.

These are parts of who I am and descriptions of how they may have a bearing on my interpretation of the process of and data from this study. They also contribute extensively to why this project was conceived and brought to fruition. My stance is necessarily limited by my current identity—both as it is internally and externally conceived—and ideas. This unique perspective is also my offering, the gift I am sharing that I hope will help to fill in gaps in care, education, and support for myself and others.

Literature Review

There is abundant evidence that trauma is a severe, pervasive health issue globally (Chatterjee, 2019; Cook et al., 2017, 2019; Courtois & Gold, 2009; Magruder et al., 2017; Mew et al., 2022; Rosenbaum, 2021). Young adults, a large proportion of whom are entering institutions of higher learning, including health professions education programs, are at an even higher risk of both exposure to traumatizing events as well as the exacerbation of mental, emotional, and behavioral symptoms that may or may not be the sequelae to trauma already experienced (Cuijpers et al., 2019a; Cusack et al., 2019; Karatekin, 2016; Strauss, 2022).

There are myriad reasons for students' vulnerability to trauma. Research describes chronic and pervasive on-campus violence toward historically targeted and marginalized

groups that is both social and institutional in nature (Center for American Progress, 2019; Conron et al., 2022; Fedina et al., 2016; Jones, 2020; Parker & Johnson-Lawrence, 2022; Steinman & Kovats Sanchez, 2021). In addition, a sizable proportion of matriculating students enter undergrad, graduate, and post-graduate programs with a history of adverse childhood events (ACEs) or other traumatic exposure, for example, intimate partner violence (IPV) or combat experience (Artime et al., 2019; Cusack et al., 2019; King et al., 2017; Karatekin, 2016). In fact, there is a movement among some scholars to advocate for the screening of incoming student populations for ACEs to enable preemptive action to prevent trauma from emerging or progressing in at-risk students (Cuijpers et al., 2019a, 2019b; Cusack et al., 2019; Karatekin, 2016; Rinfrette et al., 2019).

For students in graduate and specialized health professions programs the overwhelming and chronic stress due to heavy classroom/lab/internship workloads; the challenges of balancing competing work/school/relational responsibilities; and/or trauma witnessed or experienced in the course of one's education, training, or work as a health professional can contribute to the onset or exacerbation of existing mental health issues. (Almhdawi et al., 2018; Cook et al., 2017, 2019; Council on Medical Education, 2019; Gowen et al., 2023; Griffiths, 2022; Hughes et al., 2021; Matejko, 2022; Mengesha et al., 2022; Perry et al., 2023).

According to McAuliffe et al. (2019) "students represent a vulnerable and unique sub-population" within academic institutions. The positivistic paradigm that pervades Western scientific endeavor tends to view expressions or explorations of emotion that may emerge in research or researchers as an uncontrollable variable that could "contaminate" data and any results drawn from it. As a result, students, particularly those in the STEM fields, may experience immense implicit pressure to minimize what they are feeling and

push through with the work they are doing no matter how it may be affecting them or their lives (McAuliffe et al., 2019; Mocnik 2020; Petrone & Stanton, 2021; Pihkala, 2020).

Additionally, students may experience stress about a real or perceived lack of job security (if they are currently employed within the institution) as well as an absence or paucity of institutional support resources, such as trauma-informed supervisors; encouragement *and built-in time* to utilize campus or other counseling services; and IRB requirements to develop self-care plans as a mandatory part of research applications (Drozdzewski & Dominey-Howes, 2015; Harrison et al., 2020; McAuliffe et al., 2019; Mocnik, 2020; Nikischer, 2018; Pihkala, 2020).

Another potential vulnerability is that people who enter the healthcare professions are likely to be those who are intrinsically motivated to create positive change and help others. Many people who share this motivation have a history of trauma that may make them vulnerable to experiencing re-traumatization or secondary trauma (Benuto et al., 2018; Cuijpers et al., 2019a; Cukor et al., 2010; Cusack et al., 2019; Karatekin, 2016; King et al., 2017; Lehrner & Yehuda, 2018; Newell, 2017; Pihkala, 2020; Rinfrette et al., 2021; Smith et al., 2021; Vrklevski & Franklin, 2008). Even those without a trauma history may be susceptible to developing “researcher guilt and discomfort” or difficulty setting boundaries around engaging in activism or offering assistance on behalf of those with whom they are working. These moral quagmires can lead to vicarious trauma when support for navigating them are lacking (Cook et al., 2019; Drozdzewski & Dominey-Howes, 2015; Mocnik, 2020; Nikischer, 2018; Pihkala, 2020; Vrklevski & Franklin, 2008).

Healthcare professionals are particularly susceptible to the onset of moral distress, which left unacknowledged or unaddressed, can progress to moral injury, a form of burnout and trauma (Mengesha et al., 2022). As Hughes et al (2021) explain, “even well-

resourced clinicians experienced periods of degraded well-being, not because they lacked resilience, but because they were overpowered by the incongruence between resources and the demands of the situation" (McAuliffe et al., 2019). As social determinants of health in the United States continue to impede access to adequate healthcare, situations that put healthcare workers at greater risk of sustaining moral injury and trauma multiply and intensify.

Unfortunately, research shows that there are multiple challenges with addressing and treating mental health care issues, including trauma, on campuses of all types. One of the primary problems cited in scholarly literature is the underfunding and under-resourcing of university counseling centers. The Center for American Progress found the "average student-to-counselor ratio among state flagship universities is 1,300 to 1" and cited the Association for University and College Counseling Center Directors reporting a ratio of "1 to 1,411 from July 2017 to June 2018" (Center for American Progress, 2019).

A lack of adequate trauma and cultural competence training, long wait times, and costs to students also contribute to the problem of recognizing and treating trauma and encouraging uptake of mental health care services in the student population (Artime et al., 2019; Center for American Progress, 2019; Cuijpers et al., 2019a; Griffiths, 2022). Even where adequate university resources for mental healthcare exist and are advertised, students seem to prefer not to use them or to use services that are off campus (Artime et al., 2019; Cook et al., 2019; Cuijpers et al., 2019b; Cusack et al., 2019; Kang et al., 2021).

Finally, there is substantial evidence of a critical lack of trauma training not only in the fields of psychology and social work, but throughout the health professions generally (Cook et al., 2017, 2019; Drozdzewski & Dominey-Howes, 2015; Harrison et al., 2020; McAuliffe et al., 2019; Mocnik, 2020; Newell, 2017; Nikischer, 2019; Parker & Johnson-

Lawrence, 2022). This lack exists alongside a burgeoning awareness and evidence base that not only is explicit trauma and self-care training essential for the professional and personal development and well-being of healthcare professionals, but for professionals in ancillary fields as well (Cook et al., 2017, 2019; Hughes et al., 2021; Kang et al., 2021). Where formal trauma and self-care training is lacking, professionals are left to cobble together training via continuing and self-care education, a haphazard approach that can leave them and those they serve at risk of inadequate treatment and vicarious or secondary traumatization (Cook et al., 2019; Courtois & Gold, 2009). There is some evidence that this gap in training can also exacerbate existing health disparities and bias (Cook et al., 2019) and take a toll on the social networks of traumatized individuals, including student peers, colleagues, family, and patients/clients (Center for American Progress, 2019; Cusack et al., 2019; Mengesha et al., 2022).

Apart from contributing to the understanding and healing of trauma, another reason it is important for health professions students to be formally educated about trauma is because of their vulnerability to it and how it can affect their work and their professional lives (Newell, 2017; Nikischer, 2018; Pihkala, 2020). There is evidence that secondary trauma can affect one's research and work in deleterious ways (Benuto et al., 2018; Loomis et al., 2019; McAuliffe et al., 2019; Mocnik, 2020; Nikischer, 2018) and that having effective training in trauma and working in trauma-informed ways can actually make it easier for students and researchers to work with greater empathy and facility in complex public health situations (Mocnik, 2020; Parker & Johnson-Lawrence, 2022).

Where trauma training and awareness does not exist within academic institutions, both classroom and clinical/internship experiences are more likely to exacerbate or initiate trauma than if trauma training was integrated into the curriculum. There is good evidence

to suggest that the demands and institutional expectations inherent in pursuing higher education, particularly within the current neoliberal milieu, can trigger past trauma or even act as a primary traumatic stimulus for students and faculty (Drozdzewski & Dominey-Howes, 2015; Harrison et al., 2020; Loomis et al., 2019; McAuliffe et al., 2019; Mocnik, 2020; Nikischer, 2018; Petrone & Stanton, 2021; Smith et al., 2021; Steinman & Kovats Sanchez, 2021). In addition, classroom materials, pedagogical methods, and subject matter confronted by students in many fields of graduate study, including public health, can readily catalyze vicarious or secondary traumatic responses. The stakes become even higher when students begin to enter internship experiences and participate in or initiate research projects and they are at increased risk of incurring primary trauma from things they hear, see, do, are powerless to do, or experience personally (Harrison et al., 2020; Hughes et al., 2021; Jones, 2020; McAuliffe et al., 2019; Mocnik, 2020; Parker & Johnson-Lawrence, 2022; Mengesha et al., 2022; Petrone,& Stanton, 2021; Pihkala, 2020; Rinfrette et al., 2021; Steinman & Kovats Sanchez, 2021; Vrklevski & Franklin, 2008).

It's important to understand that being exposed to *potentially* traumatizing experiences, including the intense stress of studying and working in the health professions, does not lead *ipso facto* to diagnosable trauma and mental health problems (Courtois & Gold, 2009; Young, 2009). It's equally crucial to understand that unrelenting stress and vicarious trauma *can progress* to diagnosable trauma and PTSD if the individual is unable to find the inner and outer resources necessary to cope with the challenges they are facing (Mol et al., 2005; Smith et al., 2021; SAMHSA, 2014). This is one reason why there is an increasing call for a proactive approach that endorses screening incoming students for heightened mental health vulnerabilities and taking a preventive approach (Cuijpers et al.,

2019a, 2019b; Cusack et al., 2019; Harrison et al., 2020; Karatekin, 2016; Lehrner & Yehuda, 2018; McAuliffe et al., 2019; Rinfrette et al., 2019).

Working through the emotional and somatic challenges that arise in response to experiencing traumatic events can have positive benefits and offer personal and post-traumatic growth (Harrison et al., 2020; King et al., 2017; Lehrner & Yehuda, 2018; Mocnik, 2020; Pihkala, 2020; Rinfrette et al., 2021; Smith et al., 2021; Vrklevski & Franklin, 2008; Young, 2022). However, this type of outcome typically does not happen without the time, space, and resources—human and otherwise—necessary to confront and cope with the often-overwhelming feelings, sensations, and thoughts that accompany traumatic experiences (Courtois & Gold, 2009; Drozdzewski et Dominey-Howes, 2015; Harrison et al., 2020; Lehrner & Yehuda, 2018; McAuliffe et al., 2019; Mengesha et al., 2022; Pihkala, 2020).

While research on the topic of traumatic stress in students and faculty in higher education continues to be sparse and inconsistent (Benuto et al., 2018; Harrison et al., 2020; Mocnik, 2020; Pihkala, 2020; Vrklevski & Franklin, 2008), what does exist shows that even where educational programs offer trauma training, it is largely ineffectual and fails to prepare students for how to identify trauma and its effects, the potentially traumatizing demands they will face in their work, or how to care for themselves in the midst of these demands (Drozdzewski & Dominey-Howes, 2015; Harrison et al., 2020; McAuliffe et al., 2019; Parker & Johnson-Lawrence, 2022; Pihkala, 2020).

Nor do most academic programs adequately prepare faculty supervisors in mentorship or support faculty and researchers when they are endeavoring to maintain equilibrium amidst difficult research or classroom materials and strenuous work/life demands (Drozdzewski & Dominey-Howes, 2015; Harrison et al., 2020; McAuliffe et al.,

2019; Mocnik, 2020; Newell, 2017; Nikischer, 2018; Parker & Johnson-Lawrence, 2022; Pihkala, 2020). Supervisors and faculty who have trauma training and have support of their own have been shown to be critical in helping students manage potentially traumatizing stress and situations while those who do not have this training can have a deleterious impact on students (Cook et al., 2017, 2019; Gowen et al., 2023; Harrison et al., 2020; Hughes et al., 2021; Loomis et al., 2019; McAuliffe et al., 2019; Mengesha et al., 2022; Newell, 2017; Nikischer, 2019; Pearson et al., 2021; Rinfrette et al., 2021; Vrklevski & Franklin, 2008).

At this juncture in human history this lack of training and support may undermine the ability of health professions students and professionals, particularly those in the field of public health, to acknowledge and address health disparities and mental/behavioral health issues as effectively as they otherwise might. As Parker & Johnson-Lawrence (2022) wrote, “Trauma is an unavoidable component of public health work, especially in addressing health disparities, inequities, and social determinants of health.” Learning about trauma—its etiologies, forms, symptoms, clinical course, and treatments—is imperative for public health students to become effective public health professionals. Having an explicit and practical knowledge about the complexities of trauma will better enable students to make connections between traumatizing systems and individual and group physical and behavioral manifestations of ill health or well-being, guiding their research and development of interventions. It will also enable them to more easily bridge the connections between mental and physical health (Lehrner & Yehuda, 2018; Loomis et al., 2019; Parker & Johnson-Lawrence, 2022; Pederson et al., 2018; Petrone & Stanton, 2021; Rinfrette et al., 2021; Smith et al., 2021).

Additionally, a strong argument can be made that public health students and professionals should be among those contributing to the somewhat contentious and controversial conversations about what trauma is, what distinguishes trauma from traumatic or chronic stress, what differentiates secondary or vicarious trauma from primary trauma, and what is important to prioritize in fostering healing of trauma in its various forms and manifestations (Cukor et al., 2010). Trauma entered the *Diagnostic and Statistical Manual (DSM)* in 1980 and the criteria have shifted, added to and subtracted from in each new edition over the past forty plus years.

As the global human population becomes more interconnected and we are all exposed to a greater number of specific trauma events and ever more diffused trauma responses, there is increasing debate over what qualifies as a "diagnosable" trauma and who is actually "traumatized" (Jones & Cureton, 2014; Lehrner & Yehuda, 2018; Marshall et al., 2008; McNally, 2009; Young, 2022). With their work among diverse groups and focus on how systems and environmental influences contribute to and are affected by trauma of various types, public health students and professionals need to make themselves part of what is now more properly a sociological (communal) rather than a purely psychological (individual) health phenomenon of urgency.

Although McNally (2009) raises an important caution about the potential for "medicalizing temporary distress reactions" in the current confused and chaotic social environment, it is equally important to understand that there are potentially millions of people "who fall short of the diagnosis for the full [PTSD] syndrome but nonetheless display significant distress and functional impairment and may be at risk for full PTSD" (Cukor et al., 2010; Mol et al., 2005). Health professions students and workers are likely to fall into this category and research reveals that while some percentage of those who suffer

subthreshold symptoms of PTSD will recover fully, another number will go on to develop worsening deterioration and diagnosable trauma (Cukor et al., 2010; McNally, 2009; Smith et al., 2021).

All of this points to an explicit ethical imperative to cultivate greater awareness of and responsiveness to trauma. Indeed, the ethical rationale for offering trauma training and institutional support for students, faculty, and researchers with regard to trauma was stated repeatedly in, as well as strongly implied throughout, the literature (Cook et al., 2017, 2019; Drozdzewski & Dominey-Gowen et al., 2023; Howes, 2015; Hughes et al., 2021; Kang et al., 2021; McAuliffe et al., 2019; Mocnik, 2020; Newell, 2017; Nikischer, 2018; Rinfrette et al., 2021).

At this point we don't really know what we know about trauma awareness, teaching, and treatment on the UNMC and COPH campuses. No survey or research has been done to investigate how trauma is being taught and addressed and where there are gaps in trauma training and treatment. This Capstone project seeks to begin the process of exploring this subject in an effort to identify and describe strengths and weaknesses in the UNMC COPH community's approaches to trauma training and treatment. The project will assess the UNMC COPH campus community's level of readiness to address trauma and make recommendations for further research and action.

Methods

The University of Nebraska Medical Center is a midwestern American university based in Omaha, Nebraska, with four additional satellite campuses throughout the state. It is comprised of six colleges and two institutes, all of which are dedicated to the health professions. Current student enrollment in all six colleges is currently just over 4,500. The

College of Public Health, headquartered on the Omaha campus, has 442 students at present, 68% of which are online and distance learning students. Because of its online student population and its orientation toward public health, the COPH has a diverse and dynamic student body, representing nations from around the world, as well as a spectrum of life experiences, with 51% of its students being over the age of 30. The COPH was consistently described by participants in this study as cosmopolitan, non-traditional, and unique, “a community on the leading edge of pushing the rest of the UNMC community to think and engage more deeply around issues that matter” (Administrator).

The College of Public Health community was the focus for this project. It was my intention to interview between 8 and 12 participants, including representatives from each of 6 sectors of the COPH: the Offices of Inclusion & Equity, Counseling & Psychological Services (CAPS), the Division of Student Success, and members of administration, faculty, and the student body (current or recently graduated). To locate potential interviewees, I looked through websites for the Departments of Health Promotion & Environmental, Agricultural, and Occupational Health; the Division of Student Success; and the Offices of Inclusion & Equity to find individuals who I thought likely to be in positions where they confronted potentially traumatizing situations and/or would hear from students or colleagues about struggles or traumas they faced. I also sought out people who taught or worked in potentially challenging areas, for example, Maternal/Child Health, Climate Science, Student Services, CAPS.

I compiled a list of 24 potential participants and began to contact them via email, attaching the Informed Consent form that detailed the purpose of the study, requirements of participation, risks and benefits, etc. (See Appendix A for sample email and Informed Consent). I emailed several people at one time and if I received no response, I followed up

with a second email after one week. In both emails I included the Informed Consent, explained the time commitment involved, and offered possible meeting dates and times, as well as my contact information and encouragement to get in touch with any questions or concerns.

Because of time and energy constraints, if I received no response after the second email, I initiated contact with a new person on my list rather than continue follow-up. When I had difficulty locating a second student to participate, I contacted the Capstone office, and they sent out an email to the Capstone class via Canvas. I received one response and was able to interview that person. I continued reaching out until I had gathered a total of 9 participants.

When I did receive an agreement to participate, I immediately confirmed a meeting date and time and sent a Zoom link. Two days prior to each interview I sent out a confirmation email that included the following: a Zoom link, Informed Consent, “The Rights of Research Subjects” document (Appendix A), and the “Interview Focus” (Appendix A), which defined and clarified the subject matter at the heart of the interview. If I had not yet received a signed consent form, I asked that it be sent as soon as possible. I received a signed consent form for all participants prior to conducting each interview.

I organized the interview script using the questions from the Community Readiness Model (CRM), adding a few questions at the end regarding formal trauma education for COPH students and faculty (Appendix B). I then piloted the script with two volunteers unaffiliated with the UNMC or the COPH. The biggest concern emerging from the practice interviews was the question of how much time was required to get through the entire script even without the added questions. However, it was difficult to know what to edit out because it was impossible to predict which subjects would organically arise within each

conversation. As a result, I edited the interviews within each conversation, integrating questions from each of the five domains of interest to the CRM, while limiting repetition.

I also created an infographic entitled: “Psychological Trauma: Signs & Support” (Appendix A). After each interview I attached the infographic to an email thanking participants and encouraging them to follow up with me if they had any questions, concerns, or further ideas to share.

Using the Community Readiness Model

I used the Community Readiness Model (CRM) to organize and guide my research (Tri-Ethnic Center for Prevention Research, 2014). The CRM was developed to gather input directly from group members who occupy various roles within a community. Predicated on the “Transtheoretical Model of Behavior Change,” the CRM analyzes information from respondents to evaluate a community’s readiness to change based on information about five key domains: Community Knowledge of the Issue, Community Knowledge of Efforts (to address the issue), Community Climate, Leadership, and Resources (available to address the issue). Additionally, the CRM recognizes nine stages of readiness along which a community can develop, from no awareness and denial/resistance about a topic through pre-planning and stabilization of resources and efforts to address an issue to full community recognition and ownership of an issue.

For this project, the five domains were focused on the following:

1. COPH community knowledge about trauma, trauma training, and trauma treatment
2. Community knowledge about efforts to address trauma on campus
3. Community attitudes and concerns about trauma
4. Community leadership’s attitudes about trauma and their investment in the issue

5. Resources available for the development and implementation of efforts to address trauma on campus

While the CRM was useful in helping to guide my research and structure the interviews, there were several issues I discovered through the process of implementing and scoring the CRM that made its application to this project somewhat problematic.

First, although there are efforts on the COPH campus to provide mental health resources for students and faculty, the fact is that there are currently no resources that specifically intend to or that have been developed to address psychological trauma. Apart, perhaps, from individual psychotherapy, any resources or efforts that do happen to address trauma do so incidentally, not purposefully. Therefore, any score having to do with resources/efforts to address trauma would necessarily be a zero. In order to acknowledge that there is some effort to address mental health wellness in the COPH community, I chose to modify the dimensional instructions to the protocol: I scored "Community Knowledge of Efforts" as community awareness of mental health resources generally, and I added a sub-dimension, "Knowledge of Specific Efforts" for any mention of specific mental health interventions being implemented on campus that may or may not indirectly address trauma.

Related to this issue of available resources is the problem of attempting to determine how many faculty, students, and staff at the COPH actually do know about what is available in terms of mental health support. The inability of a few community members to definitively state what a majority of the group may actually know with regard to available resources is likely to be a pitfall of using the CRM. Yet I think it's important to shine a light on this finding: While we can assume that many or most members of the COPH community are exposed in their orientations to information about what mental health

resources are available and how to access them, *we actually do not know* how many people, if asked, would be able to name or find these resources. One participant had difficulty recalling the acronym CAPS, though they knew there was a therapy service for students on campus and had, in fact, used it at one point.

Further, 68% of the COPH student body is online. Online students do not have the same access to campus mental health resources as on campus students do. We do not have any data on how many of them know this, how many have attempted to access resources and have been denied, and how many of them are seeking mental health care away from the school.

Finally, there is an absence in the data, something to be heard in what is not being said. A few participants were able to name specific mental health interventions, such as Mental Health First Aid and Quick Check, that are available and are being either sporadically or systematically implemented throughout the university. One person had participated in one of the courses and one is a trainer. However, the majority of those interviewed did not mention these efforts, either by name or description. There is no clear way to integrate this absence into the scoring. I created the sixth domain in part to both acknowledge the presence of this awareness, as well as its absence.

One general limitation of the CRM is that individuals within any community are necessarily limited by their sphere of influence and action. It would be difficult for any one person to know what is happening in multiple other parts of a community as diverse as the COPH campus, especially with such a large percentage of online students composed of people from around the world. Having acknowledged this, however, one finding from the research is that there are gaps in communication among various departments and parts of the campus community, perhaps particularly from the university to the college level. A

faculty member described the potential for a “trickle down” effect regarding mental health awareness from the university level to the colleges, and an administrator in the COPH said that their “relationships don’t go very deep into the faculty.”

One teacher and administrator at the university level said, “I think sometimes I’m so disconnected with what each college is doing without there being a significant reporting structure and things like that. A lot of times I have no clue what folks are doing.” This statement stood out to me particularly because this person’s position is integral to diversity and inclusion work on campus. Any work to address issues of equity or psychological trauma on campus will need to acknowledge and integrate the other.

I used the CRM interview questions to create my interview script and added four questions. See Appendix B for the script; added questions are highlighted at the end.

Data

Scoring is guided by specific instructions in the Community Model Readiness Handbook, however there is a fair amount of subjectivity and interpretation involved. Throughout this paper I have attempted to a point out areas that seemed particularly subject to researcher interpretation as well as to account for my own perspectives.

In order to enhance the validity of my findings I did seek a second researcher to score and analyze interview transcripts. I checked with my Capstone Committee and sent out a message to the Capstone community via the Capstone office. Ultimately, since time was running out and I was not preparing the paper for publication, I chose to forego using a second scorer/coder.

I scored the transcripts according to the CRM model to gauge community readiness to address trauma within each of the 5 dimensions outlined in the CRM as well as the

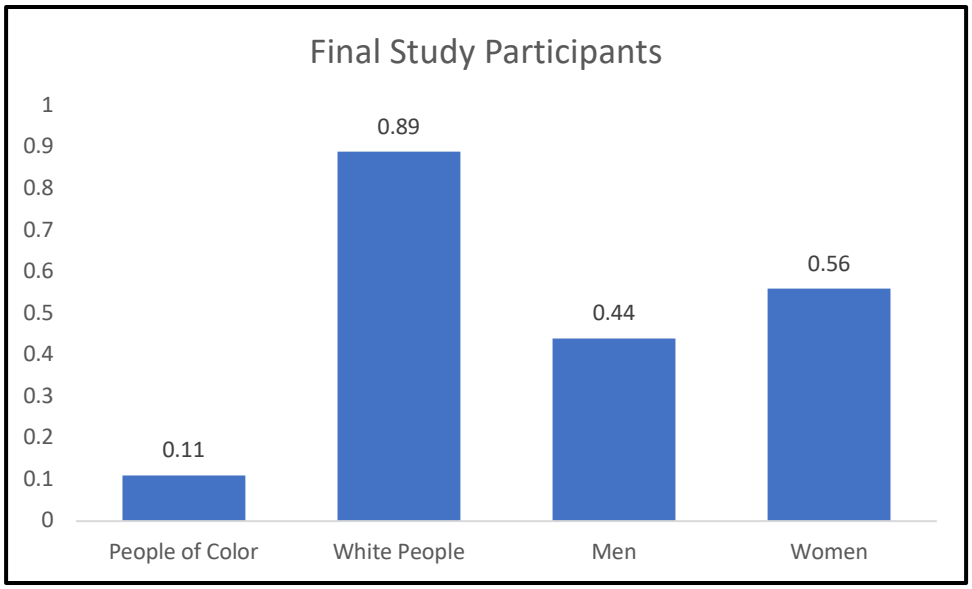
composite score. I also thematically coded the transcripts in order to discover patterns that may not have been captured by the CRM's foci and enhance my ability to identify strengths and gaps and make recommendations.

Results

Demographics (Graph 1)

The nine people who consented to be interviewed represented a wide spectrum of COPH sectors and myriad levels of the college and university hierarchy: There were 2 students, one current, one recently graduated; one person affiliated with the counseling center; one person associated with the Offices of Diversity & Inclusion; 2 COPH faculty members; and 3 staff members from the Division of Student Success. Two of the nine are high ranking administrators, 1 with UNMC and 1 with the COPH Division of Student Success. Three of the nine participants have advanced mental health degrees.

Graph 1: Final Study Participants



Participants were fairly evenly divided in terms of gender, male and female, however, there appears to be a lack of racial and gender diversity.

This lack of diversity in my sample group contributed to my musings about and interpretations of the subject matter and data in a few ways:

- First, although no photograph of me was attached to the email inquiries I sent out, some people may have made assumptions about my race, and certainly my gender, based on my name. Historically people from targeted groups have been exploited in scientific research. While participation in a Capstone project may not seem like a big deal, knowledge of intergenerational, historical, and personal trauma tells me that there may be solid conscious and unconscious reasons why a person from a marginalized group would choose not to participate in speaking to a White woman investigating the subject of trauma awareness, training, and treatment on campus. **This caused me to wonder specifically about the prevalence of trauma and traumatic sequelae (historical and personal) among people groups on campus.**
- Second, as stated in the introduction, my current understanding of racial and health inequities, as well as my knowledge about trauma and its manifestations and uneven distribution in our society, makes me aware that participating in a discussion of psychological trauma in the campus community may feel dangerous, fraught, or exhausting to a person from a marginalized group in ways that it does not to a White person in similar work or relational circumstances. **This caused me to consider that trauma and its consequences may be having an impact on how much mental, emotional, and relational energy some people may be**

expending in doing their jobs compared to a more culturally privileged person in similar work, economic, or relational circumstances.

- Finally, it's possible that people who identify in certain ways or as members of particular groups may feel their jobs or reputations at the university could be vulnerable or put at risk by their participation in a potentially difficult or revealing conversation used for research. **Thus, this *absence* within the data led me to consider the relevance of Psychological Safety as a theme in this study.**

While I do not currently have evidence to support my musings, I would argue, as Carl Sagan eloquently did, that "Absence of evidence is not evidence of absence." I would go further and submit that—particularly where there are centuries and systems of violence—absence is itself a type of evidence, just as silence can be a siren.

As a faculty participant in this study said, "I don't know really, because if people aren't talking about things, I can only guess why or why not." I cannot draw conclusions about why there is a lack of racial and gender diversity in this research. I do know, however, that to simply note it as a limitation of the research would be to contribute to the erasure of this population's experience on campus. Therefore, I have chosen to include this absence as a data point and consider it in the results and discussion.

Community Readiness Scores

Table 1 below shows the CRM score card for this project based on the transcripts of the nine interviews I conducted. Table 2 gives the Community Readiness Data Summary for the COPH with regard to psychological trauma awareness, training, and treatment. (See also Appendix C).

Table 1: Community Readiness Score Card

Dimensions	A	B	M	S	W	H	G	J	C	Average
Knowledge of Resources	6	3	3	3.5	4	2	3.5	3	2.5	**3.4**
Leadership	4	3.5	4	3	3	3.2	4.8	2.5	5	**3.7**
Community Climate	5	3	5	3.5	4	4.5	5	3.5	4	**4.2**
Knowledge of Issue	5	4.5	4.5	3	3.3	3.8	3.5	3.5	4	**3.9**
Resources	3	---	3	2	4	3	3	2.5	3	**2.9**
Knowledge of Specific Efforts	5	1	1	1	2	1	1.5	2	1	**1.7**
Overall Average CR Score	**4.7**	**3**	**3.4**	**2.7**	**3.4**	**2.9**	**3.5**	**2.8**	**3.25**	**3.3**

Table 2: Community Readiness Data Summary

Domain	Readiness Level	Score
COPH Community Knowledge of Psychological Trauma, Trauma Training, & Trauma Treatment	Vague Awareness/Pre-Planning	3.9
COPH Community Climate: Concern for and attitudes regarding trauma	Pre-Planning	4.2
COPH Leadership: Awareness of, Interest & Investment in trauma	Vague Awareness/Pre-Planning	3.7
COPH Resources	Denial/Resistance → Vague Awareness	2.9
COPH Community Knowledge of Mental Health Resources	Vague Awareness	2.9
COPH Community Knowledge of Specific Mental Health Efforts	Denial/Resistance	1.7
UNMC COPH Total Community Readiness Score	Vague Awareness	3.3

Community Knowledge of Trauma

In the first domain, Community Knowledge of Trauma, the COPH community is at the Vague Awareness stage. Psychological trauma is concerning to members and there is a feeling that it needs to be addressed, however there is no coherent sense of direction in terms of how to go about doing that. One primary reason for this is that the spectrum of perceived knowledge about trauma is broad. Independently the majority of interviewees described knowledge about trauma as running the gamut from those who show no interest or awareness of trauma to those who "are phenomenally well informed." A staff member said, "I bet it [knowledge about trauma] is different depending on which hallway you walk down," while a student said, "I feel like it really depended on who I talked to and who I was around at COPH."

Another contributing factor to the COPH being at this stage of readiness is that there may be some resistance on the part of community members to recognizing trauma—their own and others'—as a problem on campus and dealing with what would have to be confronted in the process of doing that. A staff member described this as a facet of the academic milieu and scientific paradigm prevalent at the COPH, "I think the brave face, soldiering on, 'I'm completely objective and not affected by my personal experiences' that we sometimes see in a scientific background or field, I think that may make it more difficult for people to acknowledge that subjectivity that they have."

One faculty member spoke about this resistance extensively in their interview from a perspective that touched on the personal and emotional: "…just how do we get faculty to see that this may even apply to them even if they don't realize it or don't want to deal with it? And it could apply to their students, and it could affect how we're interacting, and it could affect how students are performing, and it could affect how we're treating people, and all these different things…I think we're ready to talk about it intellectually, but we're not ready really to deal with it on the day to day."

There are also misconceptions about trauma participants mentioned that likely contribute to keeping the community readiness to address trauma at a low level. The issue of stigma was mentioned explicitly by two people and alluded to by at least three others. One person mentioned "victim blaming," which speaks to a more general tendency to view trauma as an individual and personal, rather than systemic and communal, dilemma. Others described an inclination to generalize, minimize, or "otherize" trauma.

One staff member said a common misconception they noticed is the idea "that trauma is something we study in other populations and not something that affects our population of students or particularly of faculty and staff." An administrator thought that

generalizing from one understanding of trauma, for example, learning about adverse childhood events (ACEs) and “then perhaps translating that unfairly to certain groups of people” without discrimination or nuance could be a problem. And a professor said they had “heard of people potentially minimizing a traumatic event that somebody has had to go through, or something [that] could be a traumatic event but maybe just not understanding that individual’s perspective on that.”

A staff member who has mental health training, said that what they notice most is that when people do not understand trauma, “they don’t understand how pervasive some of these symptoms can be and how it can impact for a long period of time.” People tend to run out of patience, wanting the problem to be fixed, or resisting when accommodating another’s limitations “creates extra work for them and they have to figure out ways to work with that.”

Interestingly, a student spoke to what seems to be at the root of the issue in this dimension: “I think a lot of folks have different definitions of what trauma is…I would say there are definitely different perspectives around what the actual definition is and then how that affects our students.”

Clinically speaking, what constitutes a traumatic event and how that trauma is manifested tends to be personal and unique to the individual. At the same time, there are many types of events, such as interpersonal violence (IPV) or living through a natural disaster, that have the potential to be traumatic to a majority of people. Likewise, there are scientific, evidence-based characteristics that describe trauma and are typical of all traumas, no matter who is experiencing it. The etiology, course, consequences, treatment, and healing of trauma is both varied and follows a general, common course that can be described and understood (Herman, 1992, 2023; Rothschild, 2000; Van der Kolk, 2014).

This, then, is the knowledge essential to establishing a shared understanding of, compassion for, and urgency toward addressing trauma. There is evidence that this foundational, common knowledge of psychological trauma is not present in the fabric of the COPH community.

Community Climate

The COPH's highest domain score, Pre-Planning, is in the area of Community Climate. Although members of the community may not have a lot of knowledge about trauma, there is a fairly high and consistent level of concern about it. Despite the fact that there are currently *no* resources dedicated to addressing trauma specifically, there are a few ongoing and novel efforts to provide for and safeguard mental health. Additionally, when traumatic events do occur on campus, the perception is that the leadership is quick to address these issues.

Interviewees consistently characterized the COPH community as one whose members and leadership care about the well-being of students, colleagues, and staff:

"They are concerned, they have a great level of concern for trauma and are wanting to make sure students have the right resources…" (Staff)

"from my own personal experience, I was working in public health kind of during a lot of the COVID pandemic…and I myself was having PTSD symptoms and I expressed that to some people on campus and they took me seriously and accommodated me pretty well." (Student)

"I know that there is a concern for general wellness and making sure that students are taken care of." (Student)

"I think there's a lot of us watching for those things [trauma/traumatizing situations for students] now in ways I don't think was happening before." (Staff)

Interestingly, although the perceived level of concern and care is fairly high, and three people thought that addressing the causes and consequences of trauma is a high priority on campus, there is a perception at least equally as strong that addressing trauma is *not* a high priority except, perhaps, in unique circumstances.

One faculty member said, "I don't hear a lot of people talking about it [trauma] at all…it's just not a topic of conversation…at the leadership level, I don't hear people talking about it."

When asked how much of a priority addressing causes and consequences of trauma is to members of the COPH community, a staff member responded, "Probably not very high, to be honest. Not that they're not caring, but I don't think it's hitting anyone's major radar." When asked the same question, a student said something that reveals a larger issue: "I mean, I wouldn't say it's the highest prioritized thing. My experience has been that when something comes up or is made very clear, whether it's an incident that happens on campus or me myself going up to a professor and saying, 'Hey, I'm going through something, I need a little extra time on my assignment or whatever…in reaction to that, people on campus have been very supportive and receptive, but as far as prioritizing it [trauma] over other things, I wouldn't say that it's one of the highest things."

What this statement alludes to is a theme that recurred throughout many of the interviews in myriad ways: the apparent preference to address potentially traumatic issues or incidents privately, individually, and even in ways that felt secretive. This student discussed a harassment incident on campus that took place several months ago. The administration sent out an email to everyone in the campus community letting them know

that something had occurred, and it was being investigated and "taken seriously." Initially, the student discussed this as evidence of concern on the part of school leadership. Later in the interview, they brought up this incident and email again, mentioning that "I thought it was a bit odd that whatever kind of harassment happened, [the administration/leadership] felt the need to send out an email to everybody about it. But in the email, they basically said 'we can't give any details, and trust us, we're handling it. So, I mean, it did seem like they were making efforts to take it seriously…but there was also kind of a weird element of 'don't ask any more questions' that was kind of implied. I don't know. So, I mean I feel a little mixed about that…"

This statement may have made less of an impression on me had I not had a similar experience a year prior, when I emailed a dean in Student Affairs to raise concerns about a professor who was neglecting to respond to emails, as well as failing to grade and offer feedback on assignments or post assignments and due dates in a timely way. I did receive a response that my email had been forwarded to people who would take it seriously and follow up. At no point was I contacted about my experiences, nor was I ever made privy to what resulted. When I pursued the matter, I only ever learned that "contact was made" and I was encouraged to be candid in my course evaluations.

For both me and this student this way of handling things—behind the scenes, privately or secretively, depending on your viewpoint, and with no resolution or closure—has left an unease and "mixed" feelings. Additionally, while the individual, one-on-one approach to addressing traumatizing incidents or trauma itself is an essential part of the healing process, it is widely understood by those who study trauma that it can never be healed individually, exclusive of relationship and repair of rupture(s) with others (Herman,

1992, 2023; Van der Kolk, 2014). I will address this issue in more detail in the Discussion section.

Although there are problematic aspects of the community climate, some of which are not particular to the UNMC COPH but are likely to be found in most academic institutions, the perception of the community overall was of a positive, diverse, dynamic, compassionate, and inclusive group that seeks to embody the change it wants to catalyze in the world. As a teacher put it, “So a little bit of a disconnect sometimes between what we say about issues and what we do around certain issues, but a community that is evolving and growing and, I would say, trying to do better over time.”

Leadership

This perception is particularly evident with regard to observations about how the COPH leadership has tended to respond to mental health on campus generally and potentially traumatizing events specifically. Within any community structure perceptions of who holds a position of leadership is likely to be relative. For example, students may understand faculty to be leaders within the institution, while faculty themselves view college and university administrators as those in whom power is concentrated. While acknowledging that my sample of participants represented a broad spectrum of power and leadership within the institution, for the purposes of this project I have tended to view those who hold the power to allocate financial resources and set the present and future agendas and goals of various dimensions of the COPH—educational, financial, material, moral and visionary—as well as of the university as a whole, as those who are in positions of leadership.

According to the CRM, the stage of readiness that characterizes the COPH leadership is vague awareness. Among those in leadership positions knowledge and concern about the prevalence, causes, consequences, manifestations, and treatment of trauma appears to run the gamut from no to little interest or knowledge to a fair amount of knowledge and strong concern, especially apparent when a traumatizing incident or event has taken place. This propensity of leadership to act swiftly and with initial transparency to potentially traumatizing events has fostered a general community belief that those in positions of power do care about members' well-being and will act if needed.

However, problematic patterns emerged that demonstrated that leadership's response(s) to trauma is characterized by *re*activity rather than *pro*activity; traumatizing incidents or overwhelm tend to be addressed on an individual basis; and trauma itself goes unrecognized as a unique mental and physical health problem, with an accompanying assumption that simply providing a minimum of mental health resources on campus will address traumatic issues that arise.

The tendency for not only school systems, but societal institutions and systems in general, to ignore trauma until an unavoidable and severe crisis occurs has been noted consistently by scholars (Herman, 1992; Mayor, 2018). As Herman (1992) has written, "the ordinary response to atrocities is to banish them from consciousness" (p.1). This defensive and self-preserving response is also part of what contributes to the privatization and secrecy around traumatic events and an organizational and societal preference for handling such matters on an individual basis.

One student explicitly described the support and space they personally received when they were suffering from PTSD and "some people on campus…took that seriously and accommodated me pretty well." This student also talked about a harassment incident

on campus that leadership spoke to via an email that was sent out to the campus community. Although the administration was transparent about the fact that the incident had happened and it was being taken seriously, the impression left by the email was "we can't give any details, and trust us, we're handling it."

A staff member said, "I know if there's ever a traumatic incident, things like that, they [leadership] are—they ensure that there's resources available and making sure that students are supported, their faculty are supported, staff are supported…"

One faculty member, when asked directly about how much of a concern psychological trauma is to the COPH leadership on a scale of 1 to 10, with 10 being high, said, "I'll caveat it with, when it occurs, I would say [concern is] a 10, when they've identified it, I would say a 10."

One of the students was the only one to mention the college response to the COVID pandemic, but they said, "I felt like most of my professors and especially from the administration and staff in particular…they were very good about talking to us about 'how's your mental health doing'?"

Many of the interviewees understood that there were a few specific people—primarily people in the Division of Student Success—who could be called on in the event a student was struggling. A member of faculty said, "when there's an event that occurs, when I've reached out to individuals…I think they've responded quite well and have tried their best to meet with the individuals…and provide resources and support for those individuals that have been dealing with some issue." And an administrator mentioned the "efforts that come out of the world of student affairs led by [the dean and their team…they] are very involved in a lot of one-on-one work of direct support for students."

Despite the fact that some support for mental well-being exists, some of the faculty, staff, and students have access to it, and leadership is proactive about addressing specific traumatic events, there are several problematic issues revealed in the above statements that expose large gaps in the fabric of awareness and care at the COPH.

1. The following data provide support for the finding that leadership's approach to trauma is primarily *re*active rather than *pro*active:
    - Leadership responds obviously and immediately to specific traumatic events while simultaneously there is little specific trauma knowledge among the general COPH community;
    - Misconceptions and stigma about trauma are currently identified as barriers to providing and receiving care for mental health issues;
    - There are no specific trauma training or treatment resources on campus.

2. There is an emphasis on providing care individually, one-on-one, and privately or secretively, depending on one's point of view. From one student's perspective, the tone of the email alerting the campus community to the harassment incident communicated concern, but also a sense of "Don't ask any more about it. We can't tell you what happened or how we're addressing it but trust us to do so." This lack of transparency at the campus-wide level, especially when dealing with events that may have to do with sexual abuse/violence, racial or gender discrimination, has the potential to contribute to a sense of unease and to undermine safety and trust in the administration and leadership. Establishing and/or recovering a sense of safety is paramount for both preventing and healing trauma (Herman, 1992; Rothschild,

2000, Van der Kolk, 2014). Handling campus incidents behind the scenes creates a trauma-insensitive environment.

In terms of the personal struggles of students, faculty, and staff, privacy is important when people are working through painful emotional, physical, and psychospiritual experiences. However, it is also important to be aware of two things:

a. Continuing to address mental health struggles individually and one-on-one tends to contribute to the culturally dominant beliefs that these issues are unique and shameful and that it is the individual's fault alone that they are suffering and their responsibility alone to resolve the problem. While I am in no way stating that any particular person in the COPH believes this and there is no evidence to support such a claim, the point I am making stands: When we discuss mental health issues as solely personal, private, individual phenomena; behave as if they need to be handled out of sight with the help of a few designated individuals; and fail to even study or keep detailed track of the mental health experiences of campus community members, we exacerbate the cultural problems of stigma and secrecy around trauma, its causes, and its devastating consequences.
b. Furthermore, when receiving support and help is primarily dependent upon approaching professors or administrators for help, only those who both know enough about what they're experiencing to know that it is not simply that they are not working hard enough, and, critically, those who feel safe and comfortable enough to speak up, will receive help. Although some faculty and staff may identify a colleague or student who is struggling and feel that they have the right and the resources to approach

that person, this situation requires faculty and staff to be aware of their own internalized racism or sexism, sensitive to their own emotional triggers, knowledgeable about available resources, and confident in their ability to cross over into personal, potentially painful, territory without violating boundaries.

3. This brings us to a third and fourth issue revealed in participant interviews: There are only a few people who fill roles specifically devoted to student support and a preponderance of the responsibility for identifying and addressing student mental health concerns potentially falls on faculty.

A professor said, “I think they really created [the Student Success Coordinator] position because they saw there was this gap, and it was like a lot to put on faculty…” As far as I am able to discover, there is one person at the COPH acting as the Student Success Coordinator, and currently there are 442 students enrolled. This is not a ratio conducive to the coordinator’s physical and mental well-being, let alone to ensuring responsiveness to all the students who may need support along the way.

The issue of care for faculty and staff, as well as students, also arose throughout several of the interviews. Faculty and staff seem to be mostly aware that they do have an Employee Assistance Program (EAP) and health insurance that has some coverage for behavioral health. However, the statements above make it clear that, as one faculty member stated, “At the university as a whole I see more of a focus on student mental health and supporting student mental health. And I see much less focus on supporting faculty mental health, especially kind of that idea of vicarious trauma.”

Two staff members also expressed concern about vicarious trauma for faculty and students:

> *"I think for a lot of us when we study things and work directly, we may experience vicarious trauma, particularly if you're working on subjects that we know are traumatic…We also should recognize that people's experiences that they may not have to deal with on a regular basis may come up when they get into a classroom setting and begin talking about something, for example, birth trauma."* (Staff)

> *"Well, one area that I find that we are not talking about that concerns me is vicarious trauma…because we're training future helpers in different ways, they are going to see and experience things that are going to be traumatic, and I haven't seen anyone do it well, where they're really talking about the personal impact that that can have on the helper."* (Staff)

One person who is highly placed in the administrative leadership acknowledged the role of trauma—vicarious and primary—in the lives of current and future public health practitioners: "We know significant trauma exists in the lived experiences of many of the folks who are in our research arenas…Our public health folks…we put you all into some of the gnarliest scenes on the planet."

Talebkhah-St. Claire and Cook-Cottone (2022) wrote, "There is a symbiotic relationship that occurs in the classroom, as teachers and students open up to teach and learn, a process in which aspects of the self are shared and aspects of others are taken in. Students struggling to self-regulate, cope, and learn as a result of their own lived experiences can add (often invisible) labor to the role of the educator. A compelling title of a piece by educator Emelina Minero (2017) spoke to this: 'When students are traumatized, teachers are too'" (p.130).

Musing on the mutuality that exists between student and teacher, a faculty member spoke extensively about how faculty members' traumas or psychological difficulties might also affect students' well-being: "But how can faculty help students if faculty haven't helped

themselves with their own traumas, with their vicarious traumas, all the things? So that's definitely a gap."

What stands out in the domain of Leadership are both strong positives and strong negatives. Overall, though, it would appear that the *emotional and intellectual* aspiration to prioritize well-being, to provide resources in support of students, faculty, and staff, and to act swiftly, unhesitatingly, and effectively on behalf of those who need support is present. Now that non-material energy needs to be met with material and financial resources; tangible, manifested energy; and a psychospiritual commitment to transition through difficult, potentially painful, terrain to cultivate a truly trauma-sensitive environment and trauma-educated community.

Community Knowledge of Mental Health Resources and

Community Knowledge of Specific Efforts

What material and financial resources are currently available or perceived be available to the COPH community? And is mental health care generally, and trauma education and care specifically, a budgetary priority? According to the CRM, community knowledge of mental health resources hovers at the stage of vague awareness and in the sub-dimension, "Knowledge of Specific Mental Health Efforts," the community is in the stage of denial/resistance.

Every person interviewed knew that there is a counseling center on campus, Counseling and Psychological Services (CAPS), that is available to students, and at least one student has used this resource. Faculty and staff also knew about the EAP program and one administrator and faculty member mentioned that the health care coverage offered by the university included behavioral health care benefits. However, beyond this

only a few people knew about any specific mental health efforts and most of the knowledge about who the resources are for, how to access them, and how they work was general and scant. They seem to be described and viewed as a safety net, but not as an integrated part of the community or an essential source of health care.

The consensus was that both groups—staff and students—learned about mental health care resources during their orientations. What is not known is how many students, particularly online students, are actually present to learn about these resources or retain knowledge about what is available and how to access it. Most interviewees felt that if students missed the information in orientation, they would be able to locate it on Canvas or by perusing the UNMC COPH website. However, a few potential problems with learning about and/or accessing campus mental health resources were broached by participants.

Two people described the UNMC website as “really not being a great place for finding information” (Staff) and “[not] the easiest to navigate” (Administrator). A couple of people mentioned on-site fairs or flyers as places where a lot of students might find information about wellness events and mental health resources. However, these channels of communication generally will not help online students, and even events that are offered virtually may not be effective due to the erratic schedules and time zone issues confronting the majority of off-campus students. Campus emails and e-newsletters, as well as virtual and on-campus forums were referred to by an Administrator. While in many ways there seems to be a plethora of places to find information, it seemed that the information people actually had was limited to what they had been able to access or interact with personally or had been exposed to repeatedly in multiple places/times.

One online student recognized the fact that for students not living in the Central Time zone, attempting to make appointments with the counseling center might be

challenging or, in fact, impossible, as in the case of students in other parts of the world. What no one mentioned, but one staff member confirmed, is that global students, or even students in states other than Nebraska and Iowa, are unlikely to be able to receive care from CAPS due to state licensure laws that prohibit therapists from working across state lines unless licensed in those states.

In order to cope with these limitations CAPS is purportedly working to create some licensure compacts across state lines. Additionally, every state has different rules, so part of the responsibility of therapists on staff—when approached for help by an out-of-state student—is to research state laws and local resources in order to help connect that student to mental health care that cannot be offered directly by CAPS. If the issue being confronted by the student is not severe, a CAPS therapist might offer a non-therapeutic, coaching or trouble-shooting approach to working with the student, helping the person find ways to resolve specific, time-limited challenges without delving into emotional concerns or root causes. However, "if someone was like, 'I have a trauma I need to deal with,' we are like, 'we can't.' That, we won't do, because there is no coaching through that" (Staff).

Finally, stigma, a perceived absence of support, and a lack of knowledge about trauma so that a person may not even be able to recognize that what they are struggling with is not a personal failing, someone else's fault, or a temporary dip in functioning, were also cited as reasons why people may not be able or may choose not to seek or access mental health services.

"…maybe they feel like nobody cares, so they don't seek any assistance…just somebody may be feeling like somebody doesn't care or not feeling safe to share what's happening. Not understanding what's happening, because sometimes people will share it

with somebody else, like, ‘this didn’t sit well with me,’ and [the other person is] like, ‘no, well, you have to report.’” (Administrator)

In terms of specific mental health efforts to address trauma, it is important to first note that there are currently *no* mental health efforts on campus specifically developed or implemented to raise trauma awareness, to educate about trauma, or to treat trauma. Although this is an empirical reality, there is a lack of consensus about this among interviewees. When asked directly, “Are there efforts in the COPH community to address psychological trauma?” the results were decidedly mixed:

An administrator said, “Absolutely,” and went on to describe how the assistant dean and their team would work one-on-one with students to address issues that arise.

A student responded, “I think so,” and discussed their experience with being a student during the pandemic and the concerned inquiries of professors regarding students’ mental health.

One student and one staff member cited the CAPS service and the Division of Student Success as evidence of trauma care but could not think of other dedicated trauma resources.

A staff member thought there were efforts to address trauma on campus, however they cited the diversity and inclusion work of the Diversity and JEDI councils as evidence of this. (The conflation of diversity work with trauma work is an interesting phenomenon and will be discussed further below. Although there is overlap between these two dimensions, they are distinctive, and it is essential to recognize and honor these distinctions in order to do both diversity/inclusion work and trauma work effectively.)

A faculty member said they “[hadn’t] seen any resources dedicated to trauma specifically,” though they did speak extensively about the need for trauma resources as well as administrative and personal efforts to make sure students knew about the resources that existed.

Critically, when asked about whether efforts to address psychological trauma exist in the COPH community, the interviewee associated with the counseling center responded, “Not that I’m aware of. It doesn’t mean there aren’t, but I don’t know of any personally.”

The conclusion that can be drawn from these myriad and diverse views is that there are at present no campus efforts that specifically seek to address psychological trauma. The spectrum of perspectives seems to stem primarily from the absence of a shared, knowledgeable, and detailed understanding of what trauma is, its effects on individuals and communities, and what its treatment entails.

Having acknowledged this, there are a couple of specific mental health interventions that have been recently implemented on campus. One of these is Mental Health First Aid, a course developed by the Australian National Council for Mental Wellbeing, which is described as a CPR-type course that teaches people how to identify signs and symptoms that may indicate when a person needs mental health support. Participants in the course also “build understanding of the impact of illness on individuals and families, and learn about evidence-supported treatment and self-help strategies” (Mental Health First Aid, 2023).

A staff member who is associated with CAPS, mentioned this campus resource, as did one other staff member who has taken the course and is enthusiastic about it. Interestingly, although CAPS makes itself available to faculty and staff who “can always request trainings of us around certain things,” it is not common for these requests to be made. I specifically asked if therapists would be able to present on trauma within the framework of a public health class and was told, “Yes.” However, this is a request that has not yet been made within the COPH.

Quick Check, an opt-out program to ensure that UNMC students are acquainted with CAPS, was mentioned only by two UNMC administrators and a member of CAPS. It has been rolled out within most of UNMC's colleges, with the exception of the COPH. Because the student body of the other university colleges are cohort groups, it is relatively simple for the counseling center to schedule 15-minute introductory appointments with students in those cohorts. The idea is that students have to make the effort to opt-out and cancel those appointments and they are more likely to show up, ask questions, and learn about how CAPS works and what it offers. The COPH does not operate on a cohort model, and as stated above, more than two-thirds of its student body are off-campus and may have difficulty accessing CAPS. The university has been considering an "opt-in" option for COPH students, although it's not clear how they will gather data about the usefulness of this intervention generally or evaluate its long-term effectiveness.

These and other campus efforts may incidentally or tangentially address trauma. EMPOWER, a UNMC student-led initiative to promote awareness and education of domestic and sexual violence, offers health screenings and education classes to women that may help to ameliorate some of the effects of trauma. Additionally, I was interested to learn that a few years ago the Student Senate actually voted to increase student fees in order to secure funds for two additional full-time therapists at CAPS. This initiative, too, indirectly acts to potentially mitigate the consequences of trauma and enhance treatment possibilities. However, it also raises a couple of questions:

- Why did the students need to recognize, address, and pay for the additional therapists?
- Is it a priority to allocate university resources—financial and otherwise—to mental health efforts generally?

COPH Community Resources

CRM questions about material and financial resources focused specifically on asking participants about the availability of volunteers, economic donations or grant opportunities, physical space for classes or meetings, and experts who could teach and/or offer treatment. A lot of those interviewed did not know the answers to these questions and didn't want to guess. For many, these domains were simply outside their area of influence and knowledge. The CRM stage of readiness for this domain was scored as denial/resistance.

Generally, people seemed to believe that there may be grant monies available for studying trauma and possibly for interventions on campus, but didn't know of any specifically, apart from one staff member who confirmed that Mental Health First Aid is currently being taught in the College of Nursing supported by a grant. Interestingly, although one of the highest placed administrators in the study explicitly stated that "the leadership is constantly scanning the landscape for funding opportunities," they were unable to point to any efforts on the part of leadership to solicit donations or write grant proposals to obtain funding to address trauma.

Access to experts was not considered much of a stumbling block, although no one knew of any trauma experts resident on campus. Likewise, finding space to hold classes or meetings did not pose a problem in most people's minds. Finding volunteers was considered a much more daunting challenge. While one staff member said they thought there would be "many" volunteers available for efforts to address trauma, the majority of those who responded to this question said there would be a "few" to "some" primarily due to personal time and energy restrictions.

A faculty member said they thought there would be “none to a few, in part because I think that, again, this hasn’t been an issue that’s been raised to the surface of our college.”

While an administrator acknowledged that they thought “some” volunteers would show up for trauma efforts, they pointed at a problematic complexity that arises with relying on volunteers for this type of work. When asked “How many volunteers would be available in the COPH community to participate in an effort to address psychological trauma?” this administrator responded,

“So, I feel like that’s kind of a trick question. Because sometimes this kind of work, I would venture to say maybe most would be volunteers, because if it’s not an initiative that the leadership sees as a problem or is then willing to address at the scope it needs to be addressed, then most of the people that are then looking to address it would end up being volunteers.”

This response brings up a crucial concern: The reliance upon volunteers and free labor to attempt to address many complex social issues is common in our current cultural milieu. Often these volunteers work unpaid hours *within underfunded organizations and frameworks,* in addition to paid work they do to support themselves. This, in turn, has the potential to trigger and exacerbate problems of burnout, moral injury, and trauma.

When subsequently asked if COPH community members and leaders would support using various resources to address psychological trauma, this same administrator said, “I think they would. I feel like if somebody else has put it together, I don’t know that they’re necessarily going to get in the way of it. And so, I think that they would support it if those volunteers put it together.”

This is, perhaps, the answer to the first question about why the Student Senate was instrumental in discussing, acting on, and providing financing for CAPS. While cultivating

student awareness of campus issues is important and empowering students to address their own and others' needs is positive, there is also a lacuna here. It is not clear if administrative staff played any role in the senate debate and vote, but it's curious that if there was, the subject of the understaffed counseling center was brought to the students rather than to university leadership.

Indeed, the question of whether allocating university monies to mental health resources on campus is a priority has to be answered empirically with a "no." This is not to say that the UNMC and COPH leadership and administration do not care about student and faculty well-being or that they do not understand the importance of mental health, and to a limited extent trauma, care.

In addition to the perceptions and examples of community care mentioned above, one administrator noted that the global perspective of the dean provides a more expansive lens to the leadership of the COPH, incorporating greater awareness of the problem and impact of psychological trauma generally. And the CAPS associate said, "Almost every time [a highly placed administrator] does one of the monthly forums…they always mention…the different mental health supports available, including [CAPS] and other support. So, I think they value it, too. I wholeheartedly believe that."

But, as they go on to say, "sometimes as far as support goes with matching dollars, that's not always the case." Table 3 shows the student to counselor ratio of both the COPH and UNMC total student populations. These numbers are based on current university statistics for the student body and information from my discussion with the CAPS interviewee.

Table 3: Ratio of UNMC & COPH students to CAPS licensed counselors

CAPS full-time Licensed Counselors: 3.5		
COPH student population:		**Student to Counselor Ratio**
Total	442	**126 to 1**
On-Campus	141	**40 to 1**
On-line	301	**86 to 1**
UNMC student population (includes COPH students):		**Student to Counselor Ratio**
Total	4555	**1,301 to 1**
School of Dentistry	301	**301 to 1 part-time counselor**
Minus School of Dentistry	4254	**1,215 to 1**

Although these ratios are consistent with those quoted in the introduction—"The Center for American Progress found the "average student-to-counselor ratio among state flagship universities is 1,300 to 1" and cited the Association for University and College Counseling Center Directors reporting a ratio of "1 to 1,411 from July 2017 to June 2018" (Center for American Progress, 2019)—these are grim statistics from the standpoint of both student and therapist mental health. Even if we assume that in any given semester CAPS is hosting its full capacity of 4 interns—that may or may not add up to two additional full-time positions—the ratios stay large (Table 4):

Table 4: Given full allotment of 4 interns that *may* add up to 2 full-time positions

IF: CAPS full-time Licensed counselors and unlicensed interns: 5.5 FT positions	
COPH Total student to counselor ratio:	**80 to 1**
UNMC total student to counselor ratio:	**828 to 1**

Keep in mind, too, that having interns on staff requires the full-time licensed therapists to act in a supervisory capacity that diverts time and energy from working clinically with students. The dental school does have its own part-time therapist, who is not accounted for in the above statistics. However, that person is in the process of leaving and no plans have yet been made to fill that position.

It appears evident that the counseling center is understaffed, under-resourced, and if not yet overwhelmed, certainly poised for it. The CAPS participant said, “How much people value it and how much [the] budget is, is not the same.” However, it could be argued that we tend to invest in those things that we value, and more in the things we value most.

Again, there is little evidence to suggest there is no or insubstantial concern about trauma at any level of the COPH. As one administrator said, “from the College of Public Health standpoint there is definitely a great concern for trauma, psychological trauma, but that doesn’t mean their knowledge is matched to the level of concern.”

There is, however, abundant evidence to suggest that there are ways in which this concern is diverted or undermined so that resources are not allocated toward addressing trauma or fortifying mental health care and trauma remains unaddressed at the community and individual levels. In the Discussion section I will consider some of the themes that arose in the interviews that both contextualize the problems facing the COPH in this regard and offer some pathways forward. Before moving ahead to that, however, I think it’s important to briefly share what I discovered with regard to the issue that catalyzed this entire project: the perceived absence of formal trauma education in the public health curriculum.

Trauma Education & the Preparation of COPH Graduates

Two of the questions that I added on to the CRM interview script were:

- "As far as you know, is trauma education included in the curriculum? What does this education include?"
- "Do you think students in the COPH graduate prepared to work professionally with traumatized populations?"

I think it is particularly revealing that the two students and two professors interviewed all essentially said "No" in response to both questions. This was qualified by one student who is in the Emergency Preparedness concentration and described several of the core concentration courses as including education about psychological trauma. One of these classes required participation in a Psychological First Aid course (National Association of County and City Health Officials). However, they had not found trauma education in the foundational public health courses taken.

The other student said that one might periodically "touch on the subject" of trauma in a class or in the Title IX training during orientation, but there is no standardized, "explicit" teaching of trauma that they encountered throughout the program. Both students interviewed thought that whether or not a COPH graduate left the program with the capacity to work with traumatized populations probably depended on the personal experience and specific course load of that particular student.

One professor, when asked if trauma education was included in the curriculum, said, "As far as I know, no," and mentioned the Emergency Preparedness concentration as possibly offering some. When asked if graduates are prepared to work with traumatized populations this teacher said, "That's a good question. I think we could do a better job of

that. I think it depends on what degree that you're coming from…but more broadly across COPH, I'm going to say no."

The second responded to both questions with a "no." Although they described that some faculty members might include the teaching of ACEs in their courses, that was the limit of trauma education that is generally taught. In response to the question about whether graduates are prepared to work with traumatized populations, this teacher said, "I would say no, in part though, because a lot of people in our programs aren't going to be direct service providers. They're often going to be, let's say, work in a health department or in a nonprofit managing grants. But to your point, they often are maybe leading community initiatives with community leaders. And people of all ranks and social classes and all the things could experience trauma in the past or in the present."

This response points to a common assumption about trauma, i.e., that unless one is going to be providing direct, clinical, psychological care to a person or group, that person does not need formal, explicit trauma training. Ironically, this bias seems to be rooted in a lack of education about trauma and exacerbates the prevailing societal belief that trauma is an individual problem that can only be addressed by a few individuals with specialized training. While I *am* advocating for the availability of and community access to those individuals with specialized psychological training, I am also promoting the idea that trauma training for non-clinical public health professionals is just as important as it is for psychology professionals, albeit presented differently.

Trauma training is valuable not only because of what it offers us as professionals, but what it offers us personally so that we can develop as human beings. Furthermore, the assumption that those who study epidemiology or biostatistics don't need trauma training because they are less likely to work directly with other human beings is blatantly erroneous

and reveals an ignorance about vicarious trauma and the potential of re-traumatization. Additionally, trauma training can be helpful to those who are tracking infectious diseases or statistics because it can offer insights into human behaviors, help us understand the repercussions of our work on others, and aid us in formulating theories and hypotheses about trends that underlay the numbers.

Staff and administrators in the COPH and UNMC had mixed answers to the questions about trauma education and graduate preparedness. One person thought trauma education was "probably woven into a lot of courses, but I don't know that it is independently a focus area." Three said that they did not know or were not aware of specific trauma education in the curriculum, and much like the students above, most said that whether or not graduates were prepared to work with traumatized populations depended on the person, their study focus and experiences.

Interestingly, the COPH administrator said "I cannot address that directly to know. I know it [trauma] is touched on as a part of significant work around ACEs related pieces and I know that finds its way into many courses, but I couldn't say directly a focus on psychological trauma." At the same time, when asked if students in the COPH graduate prepared to work professionally with traumatized populations, the response was "Oh, absolutely." When asked "Why do you think that? What leads you to believe that?" they responded, "just knowing the types of things that our people feel competent and trained to step into…there's virtually no element of society, domestic or abroad, that you're going to step into where you're not going to face the effects of trauma in the work that's happening…we prepare our graduates to be there, to listen, to roll up the sleeves…*Because they learn how to embed themselves and become community members*

in those spaces, by its very nature, they will engage psychological trauma [emphasis added]."

I quoted all of the above because I think it reveals the heart of the conflict around trauma and trauma education that exists within the COPH. There is an explicit awareness by at least some in leadership positions that public health graduates will be confronted with trauma, some of it extreme. There is also a sincere belief that students are being prepared for this confrontation, that they are "learn[ing] to embed themselves and become community members." Simultaneously, *there is no evidence available to support the contention that students are being prepared to address trauma o*r even "to embed themselves" in communities. Intellectually learning that one must be prepared to work with communities, and that communities are likely to be dealing with a spectrum of traumatic reactions and stress, does not actually prepare one to do the work. Likewise, the willingness and commitment to be of service, "to roll up the sleeves," does not give one the experience, knowledge, or tools to address trauma responsibly and wisely.

The COPH community has the resources to do better in the education it provides for students. Critically, the community also has the desire to do better and a strong interest in student and human well-being. Possible pathways forward will be discussed in the following sections.

Discussion: Culture & Context

Psychological Safety

There are several themes that emerged, both within the contexts and transcripts of the interviews. Even before the first interviews occurred, the issue of psychological safety presented itself to me as an area of exploration. The lack of racial and gender diversity in

study participants willing to be interviewed for this project caused me to wonder about psychological safety on the COPH campus. Psychological safety is characterized by an environment in which people feel that it is not only safe for them to speak up, point out potential problems, and disagree with peers and authority figures, but where vocalized dissent and candor are welcome, discussion about complex issues is ongoing and respectfully undertaken, and it is considered helpful to the group or organization when possible pitfalls or impending failures are recognized so that steps can be taken to address them for the good of all (Edmondson & Bransby, 2023; Hunt et al., 2021; Plouffe et al., 2023).

The importance of safety for identifying, discussing, and healing trauma cannot be overstated. In all the psychological research from the last couple of decades it has been shown that establishing personal physical, mental, and emotional safety within a supportive social network, and by extension restoring some sense of personal efficacy and power, is the essential bedrock upon which any healing process is built (Herman, 1992, 2023; Rothschild, 2000; Van der Kolk, 2014). Without safety first, no healing process can be started, much less effectively engaged.

Particularly, it is essential for psychological safety that there be a sense of mutual trust among members of the community. This can be cultivated by a track record within the organization that reveals a tolerance and support for risk taking, employee mistakes, and respectful disagreement. This trust is also fostered by consistent recognition of individual and team contributions within the institution, appreciation for the unique skills and perspectives offered by each member, and leadership humility, vulnerability, transparency, and inquiry (Edmondson & Bransby, 2023; Hunt et al., 2021; Plouffe et al., 2023). An administrator pointed out that, “I feel like oftentimes the leadership…is disconnected from

what's actually happening to the folks that they are leading…we're talking about psychological trauma, but oftentimes because of the limited psychological safety that the folks that they are leading may not feel comfortable sharing the psychological trauma that they've been exposed to within their COPH community."

Indeed, the role of leadership is critical in helping to cultivate a culture of psychological safety within any institution. Research has demonstrated that a "servant managerial" style of leadership that is focused on the development of others, creating a communal and collaborative culture of support, and equitable power distribution is particularly conducive to the promotion of psychological safety (Hunt et al., 2021; Plouffe et al., 2023). In particular, leaders who demonstrate genuine interest and those "who *shared* feedback within their team—who openly discussed criticisms and suggestions that they received in the past—normalized and crystallized vulnerability, opening doors for reciprocal behavior that allowed psychological safety to endure" (Edmondson & Bransby, 2023, p.68). Similarly, Mayor (2018) wrote about the importance of teachers and mentors "modeling the capacity and necessity of surviving feelings of discomfort in the classroom" when discussing topics having to do with race and pain (p.211).

At least two of the study participants mentioned that they thought sharing and transparency on the part of those in leadership or mentorship positions would be helpful. One staff member suggested creating a speakers' series where those who had experienced struggles with trauma and mental health would speak openly to the campus community about their experiences. An administrator mentioned feature articles published on campus that highlighted mental health challenges of senior leaders of the community in an effort to destigmatize these issues and stimulate conversation. While they said that these articles were distributed to all faculty, staff, and students, I have no recollection of

ever seeing one and they were not cited by any other interviewee. If these types of writings are an ongoing effort to address stigma and normalization of mental health discussions in the COPH community, their dissemination needs to be re-considered.

The issue of psychological safety is intimately connected to several other themes that arose in the course of this research:

- Diversity work, and its occasional conflation with trauma work;
- The neoliberal milieu;
- Shame; and
- Over-reliance on too few people to do the difficult work of attempting to address issues created by all of the above.

Diversity Work & Trauma

The issue of diversity, i.e., the recognition, respect for, and seamless inclusion of the experiences and perspectives of any person who is not part of the dominant White, Western, heterosexual, cisgender, economically and educationally advantaged male group, has been present from the beginning of this project. At least one interviewee, when asked about whether there were specific efforts to address trauma on the COPH campus, affirmed that there were and went on to describe diversity and inclusion efforts by faculty and staff. Other interviewees alluded to diversity work as an aspect of addressing trauma on campus.

Diversity/inclusion work and trauma work overlap in ways that are important to recognize and it makes sense that they could be conflated, especially when people do not have a lot of knowledge about trauma. Those whose identities do not obviously intersect with the dominant group are statistically at greater risk of incurring trauma systemically,

institutionally, and interpersonally. The fewer points of intersection one has with the dominant group, the greater the possibility of being exposed to traumatizing situations and the more one may be susceptible to increased traumatic stress. Therefore, acknowledging the intersections of trauma, and especially trauma-informed work, with diversity and inclusion work is both unavoidable and essential.

However, diversity/inclusion work and trauma work are distinctive endeavors, and they must be recognized and engaged as such if either is to be successful. When we conflate these two vital types of work, we run the risk of undermining both in several ways:

- First, we run the risk of identifying those who are members of non-dominant groups as traumatized whether or not those individuals are, in fact, suffering from trauma. All Black people or all transgender people are not necessarily struggling with psychological traumatic stress or symptoms. However, diversity work would have us recognize the ways in which people in these groups are susceptible to developing trauma because of the systems that tend to systematically trigger intergenerational and current traumas in these groups. In other words, diversity work is geared toward addressing structural, systemic, cultural, and attitudinal causes of trauma, not diagnosing or pathologizing individuals who may or may not be traumatized within those structures and systems.
- Second, when we conflate diversity and trauma work, we are likely to fail to recognize or acknowledge how often trauma occurs and how it manifests in those individuals who share more points of intersection with the dominant group, including full dominant group members. This neglect undermines diversity/inclusion work and paradigmatic shift in a couple of ways:

    - First, trauma left untreated tends to contribute to psychological instability, self-treatment via mind-altering substances, and mental illness. These, in turn, can foster violence, abuse, paranoia, and, in those with greater power, the ability to channel the energies of anger, depression, grief, and fear into repression and brutality, thus perpetuating cycles of both trauma and dominance/oppression.
    - Second, when trauma and mental health struggles are unseen and unacknowledged within and by dominant group members, a fiction is created and maintained that this group is somehow untainted by or immune to what may be seen as vulnerability or weakness in inferior "others." This then becomes another false "truth" about why the dominant group is dominant and part of how it reifies its social/economic position.
- Third, techniques employed to address diversity and inclusion issues cannot be adopted to ameliorate psychological trauma. While some methods and skills used for diversity/inclusion work may have overlap with some psychology approaches, generally these strategies are not adequate or appropriate to successfully address complex psychodynamic and psychosocial processes and may, if used in this way, inflict and/or re-trigger trauma.
- Fourth, when we unconsciously leave trauma work in the purview of diversity/inclusion offices and employees who are not trained to do the complex, psychological deep dives demanded by trauma, we:
    - Put those people at risk of vicarious trauma and make it difficult for them to do the work they are capable of and purportedly mandated to do; and

- Rather than taking responsibility for our own psychological discomfort about engaging in diversity/inclusion or trauma work ourselves, we delegate it. By having an office and a few employees hired to do the work of diversity and equity within an entire institution, a huge percentage of the population is able to avoid confronting internal and external questions with regard to one's own identity, one's own traumas, and one's role in others' traumas.

Currently, I have found little hard evidence to support these assertions about the risks of conflating diversity/inclusion work with trauma work. However, the reasoning is solid, and it seems likely that this dependence upon a few to do the arduous work (both diversity and trauma) that is more honestly the work of the community (to shift cultural attitudes, confront personal and group health issues. and more evenly distribute responsibility) contributes to a lack of psychological safety on campus.

Edmondson and Bransby (2023) found that "the relationships between diversity climate and psychological safety and between psychological safety and performance were stronger for minorities than whites" (p.61). In another study Edmondson and Roloff (2009) noted that when "unconscious negative stereotypes" are unacknowledged within a working group, the team's performance often suffers, and negative stereotypes tend to proliferate "in other, more subtle ways" (p.50).

While myriad forms of diversity within an organization can obviously contribute to its creativity, innovation, and success, often in groups with significant cultural differences individuals will tend to identify more strongly with their cultural subgroup than with the organization or larger group (Edmondson & Roloff, 2009). Additionally, failure to evenly distribute power within a given team or across an institution makes "ethnic diversity [more] likely to limit the effectiveness of communication by silencing less powerful team members

and reducing collaboration" (Edmondson & Roloff, 2009, p.50). This splintering and silencing effect is deleterious for organizational functioning and success (Tyumaseva et al., 2022) as well as for the sense of safety, belonging, and well-being of individuals and teams within the organization.

Silence from another does not necessarily mean that the other has nothing to say. As a woman growing and living within a patriarchal culture, I understand the strategy of silence and how much speech it may harbor. Therefore, it makes sense for the COPH to consider undertaking an investigation of psychological safety with an understanding that such an investigation will take a considerable investment of time and a commitment to doing what must be done so that those who are currently more comfortable with silence feel safe enough to speak (Hunt et al., 2021; Tyumaseva et al., 2023).

It should be noted that psychological safety does not have to do with creating a "woke" culture, a "cancel" culture, or a "politically correct" culture. Hunt et al. (2021) and Tyumaseva et al. (2022) explicitly state that frank and collaborative discussions, "not a carte blanche" approach to accepting any and all contributions and behaviors, is essential in fostering an environment of psychological safety.

Researchers also made it clear that psychological safety itself is not the goal, "but rather a factor enabling other goals" (Edmondson & Bransby, 2023, p.73; Tyumaseva et al., 2022). To attempt to make psychological safety an end in itself risks "fetishizing the work culture, and perhaps distracting people from the organization's actual mission" (Edmondson & Bransby, 2023, p.73). Instead, the path to psychological safety is paved with civility, respect, transparency, responsibility (response-ability), cultural humility, patience, and a commitment to the process of mutuality in relationship and community building.

As Douglass (2022) wrote in describing the energy devoted to creating a trauma-informed classroom, “It is unlikely that being dismissive or permitting threat and ridicule are sound pedagogical practices for any student. *It is not necessary for researchers and institutions to call for decent behavior because it might help someone who has experienced trauma* [emphasis added]. It may be wiser to explore the power imbalances and replication of social injustice on campus that allows for racial [and other] trauma, threats, and ridicule to exist in the first place” (p.99). In other words, psychological safety is more properly viewed as a desirable *effect* of actions that actively foster and acknowledge interdependence, community safety and well-being for all members, and behavioral responsibility. While this may seem a relatively simple solution to begin to enact within a campus community that has demonstrated a desire to be committed to the well-being of its members, there are a couple of powerful, paradigmatic forces at work that continue to overwhelm the positive intentions and hard work of individuals at the COPH.

The Neoliberal Milieu

Late capitalist, neoliberal philosophy has infiltrated the academy (Mayor, 2018; Toukan, 2023). Its credos of self-reliance, efficiency, individual responsibility, competitiveness, and belief in the benefits of unregulated corporations and financial markets have necessarily spawned epidemics of isolation and loneliness; conspiracy, paranoia, and fear rooted in competition; a rise in self-hatred and its companion mental illnesses such as despair, depression, anxiety, substance abuse, and IPV rooted in a failure to succeed alone or measure up; and wealth disparity on a scale never before seen on Earth (Becker et al., 2021; Card & Hepburn, 2023).

For the purposes of this project, neoliberalism was noted to be a persistent issue affecting psychological safety; reinforcing the belief in an "objective," scientific paradigm that eschews emotional subjectivity; abetting the tendency to address trauma and mental health issues on an individual basis and privately/secretively; and underlying the absence of adequate and consistent financial support for health care efforts in spite of vocal emotional and intellectual aspirations to address issues of health and well-being in the community.

In terms of psychological safety, Hunt et al. (2021) noted that "countries with market cultures may place competitiveness over the importance of discussing failures, creating a potentially toxic environment" that stultifies candor, openness, and a willingness to point out or make mistakes (p.2). This same competitiveness is clearly present in a majority of Western educational and corporate institutions. In one interview a faculty member spoke directly to this: "the overall environment itself, it is one of a little bit of higher pressure. I mean…we are graduate student serving only…We also have a strong focus on research and strong focus on kind of building within the College of Public Health as whole. So, it is a competitive environment within that realm…if you're a faculty member, you need to be actively engaged within the research community and actively engaged in pursuing funding and grant support and publishing. I mean, that's how you maintain your career."

Availability and equitable distribution of resources, organizational knowledge, and benefits or rewards is also key to fostering an environment of psychological safety (Plouffe et al., 2023). Yet neoliberalism operates under and perpetuates the belief that disparities in resources are "accurate reflections of differences in hard work and deservingness" (Becker et al., 2021, p.947).

A couple of interviewees specifically addressed the problem of attempting to address psychological and emotional issues that are seen as personal and private within the academic and scientific paradigm that prefers to view people and their work through an objective, impersonal, and dispassionate lens. The neoliberal emphasis on individual responsibility, while potentially empowering for some individuals at some times (Card & Hepburn, 2023), strengthens this tendency toward privatizing individual well-being (Douglass, 2022). Much evidence for this propensity to address issues one-on-one has been offered in the results section. However, there are nuances that a neoliberal perspective seems to add.

For example, the view of humans primarily as workers, producers, and consumers rather than as multidimensional beings with corresponding multidimensional needs. A faculty member said, “I’m not surprised that other people aren’t talking about this, working on this, because it forces us to acknowledge that we’re humans and we’re not just, like, research or educational machines. And that, I think, in the academic world is not something that is often acknowledged.”

There also seems to be an increasing reluctance to “get into the weeds of people’s personal issues…not wanting to have to acknowledge that people are humans because that makes them very complex in terms of, how does that affect your expectations of them…it’s harder to navigate the nuances of people’s needs than it is to just expect the same things of everyone” (Faculty).

A couple of times one faculty member used the phrase “trickle down” to describe thoughts about how information may gradually get disseminated across the college or from the university level down to the college level. This phrase irresistibly calls to mind the era of Reaganomics and the advent of pervasive neoliberal economic practice in the United

States and reverberates in an administrator's repeated description of having conversations with other *administrators and leaders*, rather than faculty and students, that confirmed for them COPH concern about trauma. It also offers an added perspective on another administrator's observation about leadership's "disconnect" from the general campus community and provokes curiosity about how effective "trickle down" communication and behavior are in practice.

Neoliberal educational environments tend to lionize "resilience" and "grit," encouraging students and others within that milieu to endeavor to change themselves if they are unhappy or unsuccessful rather than making any attempts to investigate or change the environment or systems they labor within (Boscovich et al., 2022). Connected to this is the capitalist emphasis on individual responsibility. In Mayor (2018) she quotes Dahlstedt (2009) who described the education system as "a site of constant 'responsibilization,'…Importantly, this 'shifts the main responsibility for injustices in the education system as well as in society at large […] from the structural to the individual'" (p.207).

Overreliance on a few

A serious consequence of this consistent shift of burden from the communal to the individual is that it places a lot of responsibility for wellness and continuing functioning of the organizational organism on the shoulders of a few. We have mentioned some of these "few" already: the one Student Success Coordinator, the 3.5 licensed therapists staffing CAPS, the 3-4 people who appear to be specifically employed by the Offices of Inclusion & Equity, and several individuals who staff the Division of Student Success.

In addition to these, much of the work of addressing and facilitating student well-being appears to fall to the faculty. In terms of students, they are the front-line workers. As such, there seems to be an unofficial mandate that they need to be aware of intervening if students are struggling and connect them to available resources, whether or not they have the training, capability, or knowledge to do so, whether or not they themselves are being triggered or undermined by their work or interactions with students.

One faculty member spoke extensively and eloquently about how mental health issues can have an impact on faculty and on students via faculty: “it [trauma] could affect how we’re interacting, and it could affect how students are performing, and it could affect how we’re treating people, and all these different things.” Mayor (2018) and Talebkhah-St.Marie & Cook-Cottone (2022) also speak to the importance of how faculty comport themselves in the classroom and how “their own embodiment speaks to students” (Talebkhah-St.Marie & Cook-Cottone, 2022, p.130).

This teacher also described the overriding focus on work and the attitude they observed of “I don’t want to deal with that, I’m just focused on work. And are people ready to acknowledge some of these things and how it may have impacted them? And then in turn, be able to acknowledge how it impacts others, because I think sometimes this resistance to talking about it might be actually just a resistance to us thinking about how this might apply to ourselves.” Additionally, this person discussed revelations gained from their own psychological and emotional journey that “gave me all the insight and compassion for everybody else, like, wow, we have a lot of people who are on various stages of that journey. And how do we honor that?”

At the same time, this same faculty member was the one person who explicitly delineated the dilemma confronted by faculty who are trying “to uphold the educational

goals…[and] maintain the integrity of the coursework or degree program" while simultaneously attempting to stay alert to the physical and mental well-being of students and colleagues. When students facing trauma, economic and family stressors, or discrimination of various types arrive in class, they may have difficulty resourcing themselves to effectively self-regulate, bear the workload, and meet the requirements of the curriculum (Talebkhah-St.Marie & Cook-Cottone, 2022). When there are only a few dedicated and specialized mental health practitioners and student support staff on campus the spillover is currently tending to fall to faculty who are generally ill-equipped to provide this type of help in terms of training, time, institutional resources, personal capacity, and willingness (Talebkhah-St.Marie & Cook-Cottone, 2022). As an administrator noted, "some faculty are exceptional about having conversations with students or colleagues if need be…others say, 'not my job. I don't want any part of that. Who do I tell?'"

Furthermore, faculty, along with all staff and administrators within any academic institution, are also implicated in the perpetuation of any problematic aspects of that institution. This complicity and responsibility are part of what must be confronted in order to create an effectively inclusive, psychologically safe, and trauma-sensitive/trauma-responsive institution (Douglass, 2022; Toukan, 2023). It also requires an individual and collective investment of time and energy in personal psychological healing. Additionally, faculty are often responsible for teaching subjects that spotlight social injustice and traumatizing events and situations and facilitating respectful discussion and integration of these topics. As Douglass (2022) writes, "It is not necessarily the role of higher education professionals to be the grief counselors that are needed as one untangles their participation in the underlying violence of one's culture" (p.102). This is what psychological professionals and para-professionals are trained to do.

Another challenge confronting faculty is that most of the resources to address mental health and well-being on campus are geared toward students. Every single interviewee highlighted the priority given to the well-being of students and were able to speak to resources available for students. While consistent concern for faculty and colleague well-being was expressed, only one faculty member and two staff members identified the lack of resources for faculty and staff as an issue and all three named vicarious trauma specifically as a vulnerable area. Noel and Doxbeck (2022) wrote that "It is plausible that higher education institutions, which seek to entice students into degree enrollment and completion, may emphasize positive student experiences over the well-being of their faculty" (p.116). While there is no empirical evidence that this is happening at the UNMC COPH, the neoliberal orientation toward viewing education as a commodity and students/parents as consumers is likely to contribute toward the development and marketing of programs and resources geared toward those prepared to pay for tuition rather than those who are paid by that tuition.

All of these aspects of our Western neoliberal cultural paradigm tend to be so pervasive that their workings are difficult to see and challenging to untangle from other cultural and psychological influences. Indeed, a distinct issue that emerged in the research that is implicated in and exacerbated by the neoliberal worldview is shame.

Shame

From a psychological perspective and considering the prevalence of trauma specifically and mental health issues generally in the American population, it seems likely that shame contributes to the campus-wide, and indeed culture-wide, reluctance to discuss and address trauma and mental health issues. Shame is increasingly implicated in research as

an integral aspect of post-traumatic distress (Dolezal & Gibson, 2022; Saraiya & Lopez-Castro, 2016). A key characteristic of shame is that it leads to social isolation, avoidance, and a host of "compensatory behaviors" that prevent the shame from being publicly seen or known. In some cases, there is, in fact, no shameful secret, but rather the fear of shame itself has led to the development of strategies that are socially and personally costly so that "what [individuals] live with is not shame, but 'what it costs them to keep from falling into shame'" (Dolezal & Gibson, 2022, p.5).

One of the unique attributes of shame is that "shame itself is shameful and taboo. As such, [it] is an 'iterated emotion'" (Dolezal & Gibson, 2022, p.4). This quality makes it difficult to acknowledge, discuss, and act on in a serious and sustained way within any organization. However, the fact that the COPH community has an intellectual and emotional desire to address trauma but has not yet done so— "we're ready to talk about it intellectually, but we're not ready really to deal with it on the day to day" (Faculty)—points to the possibility of some psychological, subconscious factor that may be at work. Judith Herman (1992) wrote in her groundbreaking book *Trauma and Recovery* that "Remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims" (p.1). In her 2023 book, *Truth and Repair*, Herman presents her research into what constitutes "justice" for trauma survivors and reveals that *not punishment and retribution*, but explicit acknowledgement and genuine remorse are the essential components of justice that contribute to the healing of trauma.

In order for any institution, including the COPH, to make headway in addressing diversity/inclusion and trauma/mental health on campus, an awareness of the hidden effects of shame must be considered and steps taken to cultivate shame-sensitivity.

Included in Dolezal & Gibson's (2022) concept of shame-sensitivity are three components: Shame is unavoidable; shame is highly unpleasant, and humans have evolved sophisticated strategies to avoid it; and "*it is incumbent upon services that work with people to acknowledge and respond appropriately to people's shame in order to mitigate its potential negative effects and impacts* [emphasis added]*"* (p.6). Because the COPH is not only an organization that works with people but is also an organization that specifically trains others to work with populations that are especially vulnerable to trauma and victimization, it is critical for the campus community to consider the impact of shame on its work and workings.

Any relationship subject to power differentials can unwittingly or overtly contribute to shame; organizational policies and procedures can inadvertently cause shame; and sometimes shame is even used purposefully "as the affective driver of the change [a group] hopes to promote" (Dolezal & Gibson, 2022, p.7). An exploration into shame and shame-sensitivity at the individual, team, and organizational level may be both a prerequisite for and an outcome of increased trauma awareness, training, and treatment on campus.

Paradigm shift

It is clear from the interviews I conducted that all those I spoke with, and a multitude of those they represented, are working with hope and determination toward a more inclusive, more compassionate and responsive community. At the same time, as I talked to people the idea of a tipping point kept presenting itself to me. O'Brien (2020) writes that "tipping points imply points of action…'the point at which people begin to perceive noise as signal'" (p.55). Yet while tipping points that throw us the final few steps into a new worldview

denote a sudden coalescence and catalyst, paradigmatic shifts tend to happen quite slowly overall as individual beliefs and behaviors evolve and change (Chin, 2020; Rodriguez-Sickert et al., 2015).

Rodriguez-Sickert et al. (2015) studied the underlying social dynamics of paradigm shifts and found that a shift "becomes more likely when each member of the community attaches a small but positive weight to the experience of his/her peers" (p.1). They also noted the influence of the environment within which the "knowledge community operates" (Rodriguez-Sickert, et al., 2015, p.11). Their conclusion that "mutually informed individual adventurers" within a community can pioneer "new and superior paradigms" supports the idea that introducing, integrating, and normalizing conversation about trauma and mental health issues on campus could contribute to a cultural paradigm shift that prioritizes and abundantly resources well-being (Rodriguez-Sickert et al., 2015, p.10).

The challenges and promises of paradigm shift are beautifully explored in Elena Toukan's (2023) abstract, "A new social contract for education: Advancing a paradigm of relational interconnectedness," a critical review of social contract theory in response to the International Commission on the Futures of Education report, *Reimagining our Futures Together: A new social contract for education* (2021). In it she describes the impact of our current neoliberal organization and its costs in terms of environmental crisis, community polarization, egregious inequality, exploitation, and oppression. She also observes, as other authors have done, that "Education is fully implicated in the transmission of hierarchical value systems, norms of ownership, power, and exploitation" (Boscovich et al., 2022; Toukan, 2023, p.5).

Within her critique lay the possibilities of a sustainable future as she deconstructs the social "contract" and suggests using a less transactional construct to move toward a

paradigm that is founded on an awareness of relational interdependence, “an ontological imperative” (Toukan, 2023, p.10). Education and its institutions are heavily implicated in the perpetuation of prevailing paradigms—one example of this being the American Indian boarding schools that explicitly sought to eradicate indigeneity by separating Native children from their families, languages, culture, and lands (Bryant, 2017; Burrage et al., 2021; Cervera, 2014) and another example being the longstanding exclusion of girls and women from institutions of learning in order to preserve the patriarchy and its privileges. However, because “Teaching, learning, and pedagogy [are] themselves deeply relational…[they] are potentially an ideal place to start” shifting the dominant paradigm and rebuilding toward a sustainable future (Toukan, 2023, p.11).

Although any profound shift, especially one predicated on exploring and unearthing powerful psychodynamic, somatic, and spiritual patterns and wounds, can be destabilizing, chaotic, and painful, transformation is only achieved via such a process. In her chapter “Trauma and Transformative Learning,” Johnson (2022) writes that transformative learning happens when “dissonance is resolved by changing or expanding frames of reference or assumptions used to understand the world,” i.e., paradigm shift (p.85).

The evidence reveals that the COPH is in the process of ripening, not yet prepared to take the first steps forward into a new paradigm of integrating trauma and mental health awareness but preparing to prepare. The COPH is an integral part of a world-renowned university system; a powerful, authoritative organization that actively works to address systems of health inequity; and an extraordinarily diverse institution. These charcteristics all position the college favorably to be a leader in creating positive change for its own community.

Interviewees described the COPH community in the following ways:

As *"a community that is ever changing…[that has] a commitment to addressing issues that arise or new knowledge."* (Faculty)

"…a community on the leading edge of pushing the rest of the UNMC community to think and engage more deeply around issues that matter, no matter where you are on the planet." (Administrator)

"…the most diverse of the colleges, the most interested in reducing health disparities…collegial, forward thinking" (Administrator)

"They [the COPH community] care deeply about the experience of people on our campus, particularly our students, and are willing to think innovatively and flexibly in order to ensure the best learning, research, teaching environment within their college." (Staff)

"I think there's a strong platform to build around for anything that's engaging within our community as a whole because I think there are people that are really wanting to be engaged and provide a supporting environment to others that are here." (Faculty)

The desire to be of service is a characteristic of the COPH and its members that is expressed consistently and forcefully throughout the interviews. There are many steps that can be taken and resources available to continue the journey onward toward a more trauma-sensitive and trauma-responsive—and as a result, a more inclusive, safer, and healthier—campus. The following sections go into more detail regarding limitations of this research project, as well as research recommendations and suggestions for actions to catalyze change.

Limitations

While the lack of racial and gender diversity is a limitation of this research, the fact that I was able to interview people from myriad sectors and across multiple levels of the

hierarchy within the college and university system is a strength. Additionally, although there are critical perspectives that were not heard, I hope I have made a case that this silence is actually a fertile area that points us toward future paths of action and research.

The fact that there is no second researcher to score and code the transcripts is perhaps the most serious limitation of the project. This is particularly true in light of the fact that I first conceived this project as a response to the significance of the gap in trauma education in the public health curriculum that I identified as a student. Indeed, my original intent for this Capstone was to develop and launch an educational module for trauma that could be integrated into one of the foundational courses. It was suggested to me that the magnitude of such a project was better suited to a doctoral dissertation than a master's thesis and also that it would be important to first establish a foundation of what seemed to be known and not known about trauma, including trauma education and treatment, on campus. This made sense to me, though the fact of my bias remains: I entered this project with personal experience that led me to conclude that there were meaningful gaps in trauma awareness and education and that COPH students may not be graduating as prepared for their professional lives as they could be.

At the same time, I also approach the subject matter and research with a lot of knowledge about psychology and trauma from prior advanced education in psychology, as well as personal experience and self-study. This knowledge is what enabled me to identify the gap in trauma education as well as the source of some of the symptoms I was experiencing. While this familiarity with the topics under investigation may contribute to some bias, it also enables me to undertake this research with some expertise, intelligence, and responsibility.

This Capstone project comprises one small, time-limited, qualitative study at one College of Public Health. The results cannot therefore claim to be generalizable to other campuses of public health. However, there are some reasons to consider that findings may be generalizable and merit further research:

Specifically, when we consider the prevalence of trauma in the general and student populations; the current level of interpersonal and interstate conflict nationally and globally; the extent of racial/sexual/gender/ableist discrimination and violence; and the pervasiveness of climate change stress and natural disasters, it makes sense that other campus communities would be facing similar challenges to the UNMC COPH. Likewise, the issues identified above having to do with psychological safety, the infiltration of neoliberal philosophy into the academic milieu, potential conflation of diversity work with trauma work, and the cultural stigma attached to mental health issues are likely to be factors affecting the lives of students, faculty, and staff across a range of American academic institutions.

Furthermore, nowhere in the 2021 Council on Education for Public Health (CEPH) "Accreditation Criteria for Schools of Public Health & Public Health Programs" is the word "trauma" mentioned (CEPH, 2021). Although one of the learning objectives for MPH and DrPH students is to be able to "Explain behavioral or psychological factors that affect a population's health," this directive is not reiterated in the competencies. To be fair, none of the competencies explicitly set forth specific physical, psychological, behavioral, genetic, social, political, or economic subject matter to be covered. However, I would submit that the subject matter used to teach the core competencies of public health may need to be deliberately considered and carefully chosen in light of the information gathered in this research.

Research and Action Recommendations

Table 5 shows a list of suggestions for further research. All areas of investigation are important and integral to creating a trauma-sensitive and trauma-responsive campus environment. However, perhaps the most pressing need appears to be the gathering of data about what is actually happening in the campus community with regard to mental health generally, trauma specifically, and perceptions about both within the college and university.

Table 5: Research Recommendations

Research Recommendations	
Psychological Safety	Assess and map the current state of psychological safety within the COPH and UNMC generally. See Hunt et al., 2021 for suggestions about how to begin and proceed.
Intra-campus & College to University Communication	Survey current perceptions about lines of communication across sectors and levels of hierarchy within the COPH and between the COPH and UNMC. Explore ways to open and enhance conversation and awareness throughout the campus population.
Financial Resources	Launch research into financial resources that may be available nationally and internationally to address trauma both on campus and for students and staff across the globe.
Human Resources	Collect information about the current level of trauma knowledge and emotional intelligence that exists across sectors and levels of the hierarchy within the COPH and UNMC.
Gather & Track Data	Begin to compile key data about what is currently happening in the COPH student, faculty, and staff populations with regard to mental health and trauma.

	Establish an evidence-based, baseline understanding about mental health in the online and global COPH community and investigate how to resource people who are geographically scattered. Appraise how many virtual wellness events are actually attended by off-campus students. Survey what off-campus students do for self-care in an ongoing way that encourages integration of self-care into academic pursuits.
Spearhead effort to address lack of mental health resources for students, faculty, and staff who are part of the COPH & UNMC community.	Explore ways to use the economic and cultural power of the institution to create cultural shifts in attitudes around mental health. Redress legal issues around licensure to ensure increased access to care for the campus community.

The tracking of population data could start at matriculation for students and at the orientation for new hires. Although the ACEs quiz may be a place to start, it has been shown to have several pitfalls and will not be adequate to the task of evaluating individuals comprehensively or over the long term (Dolezal & Gibson, 2022). At this point, simply gathering statistics on mental health histories, the seeking and use of campus resources, tracking choices to use off-campus mental health care, and compiling statistics on diagnoses would be a start. One benefit of integrating this data collection and the resulting information into the life of the campus community would be a step toward normalizing conversation and discussion about mental health and trauma into campus culture.

A second priority that expands on the first is for the COPH to find a way to resource its uniquely diverse and geographically dispersed population. Although it will be challenging to undertake this task, it is incumbent on the college to acknowledge this responsibility and extend this care to those it considers part of the COPH community and who, in return, actively contribute to the community.

The research that may help the COPH achieve these goals is a qualitative investigation into the lived experiences of students, faculty, and staff and their level of trauma knowledge and emotional intelligence. As I was interviewing participants it occurred to me that it would be both fascinating and helpful to conduct a narrative inquiry into people's personal encounters with trauma and psychological exploration. Doing this type of work on a fairly large scale would highlight more explicitly the level of psychological sophistication that exists on campus as well as illuminate what human resources are available to access and develop to create and implement interventions specifically designed for the UNMC COPH.

It would also help foster the creation of reliable and relevant intra- and inter-campus communication networks. Open, direct, and consistent lines of communication about what efforts and resources are being implemented and used to address mental health issues will need to flow freely throughout the university campus and its attendant colleges, via reliable, designated channels that everyone knows about *because they are regularly used and discussed.*

A caveat: To ensure that this research is inclusive of truly diverse perspectives and experiences, it would be necessary for the assessment of psychological safety to be done first. Based on results of that assessment, steps taken to foster the development of safety would need to be implemented prior to attempting this type of extensive narrative study.

Recommendations for Action

Table 6 enumerates recommendations for short, mid, and long-term actions that will foster a trauma-responsive and trauma-sensitive environment on the COPH campus. These recommendations are based on the data as well as input from participants who were specifically asked, “Are there any ideas you have about integrating trauma awareness, training, or treatment into the campus community?”

Table 6: Recommendations for Action

Recommendations for Action	
Short-term → Ongoing	
Hire more licensed, full-time therapists for CAPS and hire with diversity in mind	The current student to counselor ratios potentially put mental health and well-being at risk As far as can be ascertained from photos and professed pronoun use, all counselors at CAPS are White and cisgender; abundant evidence has shown the critical importance of identity diversity in psychotherapeutic practice. An element of diversity that needs to be considered is diversity of psychotherapeutic and life experience, for example, age, number of years practicing, and specializations.
Support all CAPS counselors in obtaining evidence-based, trauma treatment training.	This is an explicit goal of CAPS as only one of the therapists is currently certified in an evidence-based modality designed to address trauma, EMDR.

	Support may include financing continuing education, allowing for time off to pursue training, and ensuring that there are enough staff members available to cover absences for continuing education.
Provide funding for and hire more Student Success Coordinators	Currently there is one Student Success Coordinator and 442 students in the COPH. This does not seem to be a sustainable or health-promoting ratio.
Integrate Mental Health First Aid training for all students and faculty.	Although faculty members did mention that participating in required trainings often felt like an onerous addition to already overburdened schedules, those who mentioned this training were quite enthusiastic about it. Additionally, it seems like a feasible first step to begin stimulating discussion about mental health and trauma on campus since it is already present and ready to be rolled out. **Caveat:** It may be that more CAPS employees will need to be hired in advance of rolling this out on a larger scale since they are the ones who teach this training.
Encourage faculty to include CAPS contact information on syllabi each semester.	One faculty member mentioned that they have done this even though it is not technically "in compliance with our syllabus format." This would appear to be a simple, easy way to integrate this information in ways that students have consistent and clear access to throughout each semester. It also gives faculty an opportunity to speak about mental health care, normalizing and destigmatizing it in the process of reviewing the syllabus.
Mid-term → Long-term (ongoing)	

Get Quick Check integrated into the COPH campus	Advertise aggressively to on-campus and online students Consider encouraging professors to make the Quick Check appointment an assignment that is integrated into some aspect of their curriculum
Use CAPS to develop and teach modules	Vicarious trauma education specifically for faculty and staff General trauma education module that can be integrated into one of the foundational public health courses Dedicated trauma presentation for the student orientation **Caveat:** It may be that more CAPS employees will need to be hired in advance of rolling this out on a larger scale since they are the ones who teach this training.
Develop a speakers' series focused on trauma and mental health	One interviewee suggested that hosting a series of talks by those in positions of mentorship, authority, and power who would speak to their own experiences with trauma and mental health would be helpful in destigmatizing and normalizing these experiences in conversation. A second participant mentioned devoting one of the Inter-Professional Days (IPE) to trauma education and discussion.
Revamp the website	Two interviewees mentioned that it was not easy to navigate the website to locate needed resources; others were not sure what was available on the website and where information might be located.
Address Self-Care	Taking into account the general reluctance to add more mandatory training to people's schedule I suggest a more creative approach to encouraging self-care on campus:

	Use mentoring or partnerships within departments, for example, mindfulness partners or walking buddies Use ideas within departments or classes from books such as *The Artist's Way* by Julia Cameron, for example, morning pages, artist's dates, etc. Provide set space and time for faculty and staff to have self-care days (my mother actually called them "mental health days" when I was a teenager). These days could be paid time off to use for movies with friends, alone time, taking care of personal business, whatever they consciously identified as self-care at that time. Facilitate departmental and campus reframing of certain activities as self-care. For example, stopping to eat lunch, taking a walk or break, chatting with colleagues (about something non-work-related), drinking water, vacations with family, going to see a therapist, etc. Survey what off-campus students do for self-care in an ongoing way that encourages integration of self-care into academic pursuits.
Advocate for and work to incorporate trauma education and training into the public health foundational curriculum	At the minimum: Incorporate trauma education modules into foundational curriculum Develop and offer an elective course on trauma

Many of these recommendations, such as hiring more licensed, full-time therapists for CAPS and Student Success Coordinators, are clearly supported by the statistical data. As

a faculty member pointed out, “That [Student Success Coordinator] is a lot to expect one person to be able to…do…And I don’t know that there’s a college level commitment. So, taking it a step further and not just putting it on a couple of people’s shoulders, but kind of as a college, understand we’re interacting with humans, like that’s our work. So, it’s kind of all of our responsibility to understand these things and address these things.”

Taking an assertive approach to further integrating Mental Health First Aid and Quick Check makes sense because these are already present on campus and have begun to be disseminated. Although they do not directly address trauma, they are steps toward stimulating conversation, normalizing mental health concerns and care, and facilitating access to care. Likewise, hiring with diversity in mind and encouraging continuing education and trauma treatment proficiency in all CAPS counselors is a relatively attainable goal and there is no reason these can’t be taken into account when hiring and sustaining psychotherapeutic staff.

What may be more challenging to attain are the mid- to long-term actions. CAPS staff are available to create and teach modules relating to trauma and could potentially be called on to develop an introductory trauma module to integrate into public health foundational courses. However, up to this point the COPH has not made much use of this resource. It makes sense to ramp up use of the counseling center to provide and integrate trauma education on campus. However, CAPS staff will need to be increased before this resource can be used more extensively and consistently.

Also, one participant suggestion was to offer a presentation explicitly addressing trauma during student orientation, “just an introduction to how prevalent it is, signs to look for and ways that it could be dealt with and that could be integrated into pointing students toward counseling and psychological services that are available as needed. Because I

don't think we really got that level of knowledge in our orientation…But setting a baseline of knowledge…that, I think, would be helpful."

The modules required at the start of each school year, such as the Title IX trainings, were mentioned by a few interviewees as a place where topics pertaining to trauma were broached. But the prevailing attitude was that they did not comprise trauma education or training per se and also that the "one and done" approach (Administrator) of doing these modules was not conducive to sustained awareness or behavioral change.

Interestingly, only one participant even mentioned self-care. Yet ultimately self-care is critical to physical and mental well-being (Talebkhah-St.Marie & Cook-Cottone, 2022). Doing things to promote self-care, developing a speakers' series, and organizing IPE days devoted to trauma awareness and education can all draw on a range of human resources and expertise that may already be present on campus. They may also be enjoyable and boost morale and cooperation along the way.

Furthermore, Talebkhah-St.Marie and Cook-Cottone (2022) offer an expanded idea of self-care as "a set of regularly performed behaviors that operationalize what it means to take care of and appreciate the self within the context of your environment and relationships" (p.138). This "mindful self-care" acts as an antidote to the neoliberal narcissistic focus on the self and its perceived needs in isolation and can therefore contribute to radical change and sustainability.

Undertaking website changes is likely to be an expensive and potentially disruptive endeavor, but it should be considered as an aspect of the larger inventory of communication channels on and off campus. I recognize that creating a trauma-focused foundational course is not likely to happen in the near future. Indeed, even integrating trauma-focused modules within a course will probably meet with resistance at multiple

levels. One participant directly spoke to this. When asked about whether or not community members would support expanding efforts to address psychological trauma in the campus community, they said, “if it’s something that can be easy to implement. That is something that I think would be very supported. It’s a lot harder when you start asking people to remove things on their syllabi, for example, to bring in a different unit.”

However, as noted above, most interviewees described an absence of any explicit trauma education in the curriculum with the exception of the Emergency Preparedness concentration. There was also a notable question in most people’s minds about whether COPH graduates are actually prepared to work with traumatized populations, which is likely to comprise a large percentage of who public health professionals will work with. Even though one administrator expressed absolute confidence in COPH graduates’ abilities to work with trauma and traumatized people, this person was also unable to say with confidence that COPH students receive any trauma training or preparation.

Interestingly, everyone I interviewed has had some training in mental health care and/or trauma. Three of the nine have advanced degrees in mental health and are or have been qualified to work clinically in a psychotherapeutic capacity. One faculty member had training in trauma-informed communication, and one had gone through the Trauma Matters training offered through Project Harmony in Omaha (Trauma Matters Omaha). Students and staff members had attended trainings such Psychological First Aid, Mental Health First Aid, and victim advocacy and/or sexual assault/IPV courses. Presumably these people are not the only ones on campus with some extra education or awareness about trauma and the importance of proactively addressing mental health issues in the community, and they can be helpful in instigating and implementing change.

However, human resources must be called upon and developed with trauma-sensitivity in mind. Many interviewees described time and energy demands that they thought would interfere with community ability to marshal human resources for efforts to address trauma and trauma education. What became increasingly clear throughout this research is that in order to begin to address trauma on campus many interlocking pieces of the present paradigm, including diversity and inclusion work, the neoliberal ethos, psychological safety, gaps in communication and between leadership and the people they serve, and more, will need to be addressed and shifted concurrently in order for effective and sustainable change to happen. This is the nature of paradigm shift: we must initiate change and proceed as we wish to continue.

Toukan (2023) points this out when she describes the International Commission's "broad call and *invitation to co-creation in lieu of targeted recommendations* [emphasis added] [as] a refreshingly humble one, opening room for the kind of reflexivity and reimagining of norms needed for a more substantive paradigm shift. The call is more than a mere search for new 'rules of the game'" (p.10). The COPH community has positioned itself as a leader both within UNMC and globally with regard to acknowledging and addressing painful systemic realities and their personal and communal ramifications. The time has come to expand this remit to include trauma awareness, training, and treatment, first within its own community, and from there outward to all those we serve.

Conclusion

Something needs to be explicitly stated here: There is no way to avoid or completely prevent trauma from happening. Also, there is no way to avoid discomfort—even severe or potentially traumatizing discomfort—in the process of educating or learning. Any attempts

to deny, whitewash, or avoid subjects that might be traumatizing or disturbing to students or faculty will ultimately inhibit learning, maturation, and healthy human development.

In her chapter “Trauma and restorative landscapes in higher education,” Douglass (2022) does a thorough job of supporting her claim that the classroom is not a place that can be beneficially softened, smoothed out, or neutralized. She argues for a “restorative landscape,” where emotional and intellectual support, open and respectful discussion, and rupture and repair are present, rather than “a therapeutic landscape in which stress is privatized, and it is up to the individual to adapt” (Douglass, 2022, p.103).

Douglass acknowledges that when classroom subject matter as well as cultural norms are rife with images and facts about violence, oppression, and exploitation it normalizes these types of behavior and the views offered of the individuals who inflict harm and suffer it. At the same time, she is correct in asserting that “higher education cannot be a space of healing, comfort, and personal growth that is free from explorations of violence and justice” (Douglass, 2022, p.97). She suggests that in the process of speaking openly, supportively, and *with faculty training* about trauma in the classroom, we have the opportunity to normalize students’ lived experiences of trauma so that “those with trauma become part of the landscape, rather than the justification for why social justice work evokes such strong emotions” (p.97).

Research has established that trigger warnings are not useful in helping people diagnosed with PTSD avoid further suffering (Douglass, 2022). In attempting to ameliorate trauma and be respectful of people’s sensitivities we have instead tended to avoid difficult issues, perpetuate silencing, exacerbate polarization and stereotyping, and inflamed sensitivity. Similarly, avoiding explicit explanations and education about psychological trauma in the public health classroom, relying instead upon tangential references to

trauma—to describe events, situations, and people—that assume we are all on the same page, creates a gap that contributes to personal and community confusion, undermining safety, trust, and well-being. Jamieson (2016) writes, “An environment that promotes psychological safety will provide opportunities for psycho-education, demystifying what have previously been inaccessible psychological concepts, and making reading materials and other media available for teaching, discussion, and understanding” (p.2).

Repeatedly, throughout the research I did in support of this project, a common theme was that traumatizing events do and will occur, but incurring trauma as an outcome, diagnosis, or disorder that profoundly affects one’s health and life course is dependent upon lack: A lack of critical emotional, social, and psychological connection and support, a lack of safety, a lack of knowledge about what is happening and why, and a lack of having one’s experience heard and acknowledged as true (Herman 1992, 2023).

Talebkhah-St.Marie & Cook-Cottone (2022) explicitly spoke to this: “Trauma, vicarious trauma, burnout, and compassion fatigue are the result of the stress one experiences, yes. However, it is also the result of an acute and/or chronic lack of support and resources from systems and institutions, as well as a dearth of coordinated effort to support the well-being of communities that students and faculty hale from” (p.136).

Lack, absences, silences are always in danger of being neglected and overseen. As Herman (1992) points out, the history of psychological trauma is one of “episodic amnesia [where] periods of active investigation have alternated with periods of oblivion” (p.1). The shame and stigma surrounding trauma and its causes provoke avoidance and secrecy. However, the often disruptive, disturbing, and confusing symptoms and behaviors suffered and enacted by the traumatized tend to spotlight the individual as the source of the

problem, allowing the community, with its contributions and responsibilities, to fade into the shadows (Herman, 1992).

This is a dangerous situation because by failing to see where the gaps in care, support, education, and training are, we are perpetuating the problems, illnesses, and ignorance we claim to be in the process of addressing. The assumption that providing a bare minimum of mental health resources on campus and EAP services to employees is enough to sufficiently resource faculty, staff, and students in the face of what they confront in their classrooms, their research, their relationships, and their work is erroneous.

Apart from the fact that there are not resources to serve the numbers of people needing them, there is the fact that trauma must be treated as a unique issue, different from depression, anxiety, substance abuse, or personality disorders, even though it often contributes as a root cause to all of them. As Herman (1992) writes, “The persistent anxiety, phobias, and panic of survivors are not the same as ordinary anxiety disorders. The somatic symptoms of survivors are not the same as ordinary psychosomatic disorders. Their depression is not the same as ordinary depression. And the degradation of their identity and relational life is not the same as ordinary personality disorder” (p.118).

Trauma is already here, integrated more—or less—unconsciously into the workings of every community, including the COPH community. This project has been undertaken in the hope that more awareness about where the campus community currently stands on this topic may lead to more material support for faculty, staff, and students’ mental health as well as efforts to provide explicit, formal trauma education and evidence-based trauma treatment.

Obstacles to implementing such efforts on the COPH campus include a deficit of trauma knowledge generally in the community; the possible disconnection of leadership

from faculty, staff, and students; lack of recognized and well-used communication channels among colleges and between the COPH and the university; a current cultural paradigm not unique to the COPH that tends to stigmatize and deprioritize mental and physical health in service to production and economic profit. Resources include a consistently vocalized desire by all participants to provide for the well-being of others in the community; a universal recognition that trauma is a pervasive and serious issue that should be addressed; and a community filled with people who are hardworking, intelligent, educated, and skilled in the field of public health.

Appendix A

Informed Consent

Sample Contact Email

“Rights and Responsibilities of Research Subjects”

Interview Focus

Resources Infographic

Informed Consent for participation in Capstone Project

Title: Spotlight on mental health on a healthcare campus: Research exploring awareness, teaching, and treatment of trauma at the University of Nebraska Medical Center College of Public Health.
Principal Investigator (PI): Jenny Mueller, MPH Student, Department of Health Promotion
Supervisory Committee: Dr. Regina Idoate (Chair), Dr. Brandon Grimm, and Dr. Analisa McMillan

Purpose: This study seeks to explore the UNMC community's level of readiness to address trauma among COPH faculty, staff, and students with a specific focus on how trauma is taught and how it is recognized and treated in the campus community. There is not only abundant evidence that trauma is a global health concern, but also that students on university campuses, particularly those in the health professions, are at even higher risk for experiencing primary and vicarious or secondary trauma than the general population. Therefore, it makes sense to investigate how trauma is perceived, taught, and treated in the UNMC COPH community.

What is trauma? For the purposes of this study, trauma is understood to be a wholistic response to any event or events personally or indirectly experienced or witnessed that overwhelm(s) an individual's current capacity to cope with and integrate the stress of that/those event(s). By wholistic we mean that the signs and symptoms of trauma may manifest emotionally, cognitively, psychospiritually, relationally, and/or somatically. Also, the ripple effects of trauma may impact every aspect of a person's life.

Methods & Data: The Community Readiness Model (CRM) will be used to organize the collection and analysis of data. In accordance with this model, 6-12 "key respondents" from the campus community will be interviewed, 1-2 from each of 6 sectors: Students, Faculty, Administration, Student Services, the office of Diversity, Equity, and Inclusion, and Counseling Services/Campus Wellness.

Interviews will be conducted over the phone or on Zoom, recorded and transcribed. Data analysis will be conducted by two researchers and will include scoring, as described by the CRM, and thematic coding.

Research gathered from interviews will be used to create a report describing recommendations for future research and action.

Confidentiality: Jenny, the PI, will have access to interviewees' contact information in order to facilitate setting up interviews and conducting follow-up.

The transcription service being used is HIPAA compliant, will redact names and personal identifiers, and uses encryption to ensure security. Once downloaded to the PI's personal computer, transcriptions will be saved to a thumb drive as well as printed out to facilitate analysis. The thumb drive, contact list, and print outs will be kept in a locked safe in the PI's home for the

duration of the project. Transcripts will be shared with the second coder and, if necessary, the PI's Capstone committee. However, transcripts and subsequent writings based on interviews will have pseudonyms so that participants' identities are kept confidential.

At the completion of the Capstone project (anticipated to be December 2023), all digital records of the transcripts will be deleted and print outs will be shredded.

Requirements of participation: If you choose to participate, Jenny will schedule an interview time by phone or Zoom, whichever you prefer. Interviews will be scheduled for 30 minutes. Jenny will follow up one-week post-interview to check in and see if any questions or concerns have arisen.

Risks of participation: The biggest risk of participating in an interview is the potential for the discussion of trauma to be upsetting or uncomfortable. It's important to consider your personal history and current stress level before giving consent to be interviewed. It's also important to know that you will be able to raise concerns or stop the interview at any time. All participants will be offered contact information for campus support services available to faculty, staff, and students.

Benefits of participation: Statistically, trauma is affecting hundreds of people in our campus community. We can be more effective in addressing trauma, strengthening community support and health, and preparing future healthcare professionals for their work if we learn more about current strengths and gaps with regard to how trauma is understood, taught, and treated on campus.

Results: If you would like to read the results of this research, please let Jenny know and you will receive a copy of the report once it has been finalized and submitted for completion of the Capstone.

Questions/Concerns: If you have questions about this project or your potential participation in it, please do not hesitate to contact Jenny Mueller:
Phone: 928-203-6392
Email: jenny.mueller@unmc.edu

Signature: _____ Date: _____

Sample Email

Hello,

My name is Jenny Mueller, and I am an MPH student in the Health Promotion department. This fall I am conducting research for my Capstone project, which seeks to explore the UNMC community's level of readiness to address trauma among COPH faculty, staff, and students. I am seeking to interview 6-12 respondents from various sectors of the college: faculty, students, and administrative staff from the Offices of Inclusion & Equity, Counseling and Psychological Services, and the Division of Student Success. As a recently graduated student of the MPH program your perspective on this subject is important to include.

Interviews will be scheduled for 30 minutes and will take place on the phone or via Zoom. My father's memorial will be taking place on September 9, so I am scheduling interviews for the weeks of September 18 through October 6.

Attached to this email is an Informed Consent that more fully describes the aims, methods, and subject of this project, along with risks and benefits of participation. Please let me know if you are able and willing to be interviewed for this study. Do not hesitate to contact me with any questions or concerns you may have prior to making this commitment.

If you are available for an interview, please let me know the best day and time for you:

- Wednesday, 9/20 or Friday, 9/22 – any time
- Thursday, 9/21 – afternoon
- Wednesday, 9/27, Thursday, 9/28, Friday, 9/29 – any time
- Wednesday, 10/4 – afternoon
- Thursday, 10/5 or Friday, 10/6 – any time

I appreciate your time and attention. Thank you,

Jenny E. Mueller, CYT, LMT
UNMC College of Public Health, MPH Student
928-203-6392
Jenny.mueller@unmc.edu

THE RIGHTS OF RESEARCH SUBJECTS

AS A RESEARCH SUBJECT AT THE NEBRASKA MEDICAL CENTER YOU HAVE THE RIGHT …

… to be told everything you need to know about the research before you are asked to decide whether or not to take part in the research study. The research will be explained to you in a way that assures you understand enough to decide whether or not to take part.

… to freely decide whether or not to take part in the research.

… to decide not to be in the research, or to stop participating in the research at any time. This will not affect your medical care or your relationship with the investigator or the Nebraska Medical Center. Your doctor will still take care of you.

… to ask questions about the research at any time. The investigator will answer your questions honestly and completely.

… to know that your safety and welfare will always come first. The investigator will display the highest possible degree of skill and care throughout this research. Any risks or discomforts will be minimized as much as possible.

… to privacy and confidentiality. The investigator will treat information about you carefully, and will respect your privacy.

... to keep all the legal rights you have now. You are not giving up any of your legal rights by taking part in this research study.

… to be treated with dignity and respect at all times

The Institutional Review Board is responsible for assuring that your rights and welfare are protected. If you have any questions about your rights, contact the Institutional Review Board at (402) 559-6463.

Interview Focus

Title: Spotlight on mental health on a healthcare campus: Research exploring awareness, teaching, and treatment of trauma at the University of Nebraska Medical Center College of Public Health.
Principal Investigator (PI): Jenny Mueller, MPH Student, Department of Health Promotion

Interview focus: The aim of this project is to explore the UNMC campus community's level of readiness to address trauma among students, staff, and faculty.

Definition of trauma:
For the purposes of this study, trauma is understood to be a wholistic response to any event or events personally or vicariously experienced or witnessed that overwhelm(s) an individual's current capacity to cope with and integrate the stress of that/those event(s). By wholistic I mean that the sequelae and symptoms of trauma may manifest emotionally, cognitively, psychospiritually, relationally, and/or somatically. Also, the ripple effects of trauma may impact every aspect of a person's life.

"Trauma is a response to anything overwhelming, and that happens too much, too fast, too soon, or for too long."[1]

Trauma may occur primarily or vicariously.
In primary trauma an individual directly experiences the traumatic event physically and/or as an eyewitness present at the traumatic event. For example, a person who is shot and a bystander who witnesses the shooting may both experience primary trauma.
In vicarious trauma an individual may hear stories and/or see images of traumatic events that can have a traumatic effect on the person who is secondarily or vicariously bearing witness to the trauma experienced by the speaker or those in the images. For example, counselors who work with domestic violence survivors or researchers who work with high-risk groups such as the homeless, sex workers, or children may be at increased risk of incurring vicarious or secondary trauma.

Key characteristics of Post-Traumatic Stress (PTS) (both primary & vicarious):

1. Hyperarousal
2. Re-experiencing of event or intrusive thoughts/memories/ideation about event
3. Avoidance of any reminder or trigger to memory of the event
4. Ruptures in cognitive schema ("meaning-making"): "…the way you see yourself, the way you see the world, and the way you see other people are shocked and overturned by an event."[2]

Definition of trauma training: Trauma training is any formalized instruction focused on defining the etiology, symptomatology, progression of, and treatments for trauma. Trauma training may also include instruction about how to create trauma-*informed* curricula, classrooms, and ways of working and mentoring.

Definition of Trauma Treatment: Trauma treatment refers to any evidence or non-evidence-based treatment specifically targeting a recognized and diagnosed trauma. Treatments may be primarily cognitive, somatic, psychospiritual, or relational, or may combine these modalities.

The Community: The community being explored in this interview is the community composed of University of Nebraska Medical Center with particular focus on College of Public Health faculty, staff, and students.

[1] (Bell, K., quoted in Dietkus, R. (2022). The Call for Trauma-Informed Design Research and Practice. *Design Management Review*, *33*(2), 26-31).
[2] (Trickey, D., quoted in Dietkus, R. (2022). The Call for Trauma-Informed Design Research and Practice. *Design Management Review*, *33*(2), 26-31).

Psychological Trauma: Signs & Support

What is trauma?

Trauma is a whole-body response to any experience that feels emotionally, physically, and/or psychologically overwhelming or threatening to survival. This can include accidents, interpersonal violence, natural disasters, ongoing abuse of any kind, neglect, severe illness/injury, witnessing the death or injury of another being, traumatic loss, & more.

70%

of adults in the U.S. experience at least one traumatic event in their lives[1]

Trauma creates ruptures in meaning-making:

"...the way you see yourself, the way you see the world, and the way you see other people are shocked and overturned..."[2]

Primary Trauma

may occur when an individual directly experiences a traumatic event physically and/or as an eyewitness present at the traumatic event.

Vicarious or Secondary Trauma

can happen in an individual who hears stories and/or sees images of traumatic events. In this case the individual is traumatized by bearing witness to the trauma experienced by the speaker or those in the images. **Ongoing exposure** to traumatic stories and images increases the risk of vicarious/secondary trauma.

Signs & Symptoms of Traumatic Distress[3]

Hyperarousal

- Anxiety, panic
- Difficulty sleeping
- Inability to concentrate
- Irritability, prone to anger
- Impulsivity or outbursts
- Hypervigilance
- Easily startled or frightened
- Restlessness
- Aches and pains

Re-experiencing

- Intrusive thoughts/images
- Flashbacks: Feels as if the trauma is happening now
- Nightmares
- Intense physical sensations: racing pulse, difficulty breathing, sweating, nausea

Avoidance

- Avoiding anything that triggers memories of the trauma
- Numbing emotions or sensations to detach from feelings & the body
- Difficulty remembering details of traumatic event
- Self-medicating with addictive substances or behaviors

Evidence-based Trauma Treatments[4]:

- Cognitive Behavioral Therapy (CBT)
- Somatic Experiencing (SE)
- Cognitive Processing Therapy (CPT)
- Eye Movement Desensitization & Reprocessing (EMDR)

What triggers traumatic memories or feelings?

- Memories
- Emotions: Anxiety, fear, shame, anger, frustration, betrayal, abandonment
- Muscle tension or physical discomfort
- Certain postures
- Anniversaries of trauma
- Reminders of the trauma:
  - People, places, scents, sounds
  - Images, stories, articles, movies, podcasts, etc.
- Discussions about trauma
- Harassment, microaggressions
- Witnessing/experiencing aggression

Sources of Support for Traumatic Distress

Counseling & Psychological Services for UNMC Students: https://www.unmc.edu/student-success/support-services/counseling/students.html; 402-559-7276
UNMC Faculty and Staff Employee Assistance Program (EAP): Arbor Family Counseling: https://arborfamilycounseling.com/; 402.330.0960

Counseling in Omaha:
Affirming Joy Mental Health Services: https://www.affirmingjoy.com/, 402-230-7222
Omaha Trauma Therapy: https://www.omahatraumatherapy.com/welcome, (531) 444-1963
Counseling Connections & Associates of Omaha: https://www.ccaomaha.com/, 402-932-2296
Trauma Care for those who identify as Native American: https://www.poncatribe-ne.org/services/domestic-violence/trauma-services/, 402.315.2760
Strong Hearts Native Helpline: 1.844.7NATIVE
The Attachment & Trauma Center of Nebraska: http://www.atcnebraska.com/, 402.403.0190

SAMHSA'S Disaster Distress Helpline (available in multiple languages and for Deaf and ASL callers:
https://www.samhsa.gov/find-help/disaster-distress-helpline

References

[1]https://www.thenationalcouncil.org/wp-content/uploads/2022/08/Trauma-infographic.pdf
[2]Trickey, D., quoted in Dietkus, R. (2022). The Call for Trauma-Informed Design Research and Practice. Design Management Review, 33(2), 26-31
[3]https://www.mind.org.uk/information-support/types-of-mental-health-problems/post-traumatic-stress-disorder-ptsd-and-complex-ptsd/symptoms/
[4]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6224348/
[4]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8276649/

Appendix B

Interview Script

Interview Script

For the following question, please answer keeping in mind your perspective of what community members believe and not what you personally believe?

On a scale from 1-10, how much of a concern is trauma awareness, training, and treatment to members of the COPH campus community, with **1 being "not a concern at all" and 10 being "a very great concern"?**

Can you tell me why you think it's at that level?

KNOWLEDGE about issue

On a scale of 1 to 10 where a 1 is no knowledge and a 10 is detailed knowledge, how do community members know about trauma?

Why do you say it's a [ ]?

Would you say that community members know **nothing, a little, some, or a lot** about each of the following as they pertain to trauma?

- Trauma, in general
- signs and symptoms of trauma
- causes of trauma
- consequences of trauma
- the number of people likely living with trauma in the COPH community
- what can be done to prevent or treat trauma
- the effects of trauma on family, friends, and the campus community
- available treatments for trauma
- how to address trauma in their work
- how to teach and train others to recognize and work with trauma

What are misconceptions among community members about trauma?

What type of information is available in the campus community about trauma, trauma training, and trauma treatment?

COMMUNITY CLIMATE

How much of a priority to community members is addressing the causes and consequences of trauma?

Can you explain your answer?

COMMUNITY KNOWLEDGE OF EFFORTS

Are there efforts in the COPH community that address trauma training and/or treatment? **YES OR NO**

YES

Can you briefly describe each of these?

- *How long have each of these been going on?*
- *Who do each of these efforts serve?*
- *What are the strengths of these efforts?*
- *What are the weaknesses of these efforts?*

About how many community members are aware of each of the following aspects of the efforts – **none, a few, some, many, or most**?

- Have heard of efforts?
- Can name efforts?
- Know the purpose of the efforts?
- Know who the efforts are for?
- Know how the efforts work, for example, activities or how they're implemented?
- Know the effectiveness of the efforts?

Thinking back to your answers, why do you think members of your community have this amount of knowledge about trauma training and/or treatment?

How do community members learn about the efforts?

What are the obstacles to individuals participating in these efforts?

Are these efforts being evaluated?

Are results being used to make changes or to start new efforts?

RESOURCES FOR EFFORTS

How are current efforts funded?

Is this funding likely to continue into the future?

IF YES

I'm going to read a list of the ways that community members might show their support or their lack of support for community efforts to address trauma training and treatment. Can you please tell me whether **none, a few, some, many, or most** community members would or do show their support in this way? Also, feel free to explain your responses as we move through the list.

How many community members…

- At least passively support community efforts without being active in that support?
- Participate in developing, improving, or implementing efforts, for example by attending group meetings that are working toward these efforts?
- Play a key role as a leader or driving force in planning, developing, or implementing efforts? (How do they do that?)

About how many community members would support expanding efforts in the community to address trauma awareness, training, and treatment? **none, a few, some, many, or most**

How might they show this support?

I'm going to read you a list of resources that could be used to address trauma in the COPH community. For each of these, please indicate whether there is **none, a little, some, or a lot** of that resource available in your community that could be used to address trauma..

- Volunteers
- Financial donations
- Grant funding
- Experts
- Space

Would community members and leadership support using these resources to address trauma awareness, training, and treatment? Please explain.

Are there community members who oppose or might oppose addressing trauma? How do or will they show their opposition?

Describe the COPH campus community.

NO

Is anyone in the COPH community trying to get something started to address trauma training and/or treatment? Can you tell me about that?

How many community members would support expanding efforts in the community to address trauma? **none, a few, some, many, or most**

How might they show this support? ***(passive support, developing, or driving force)***

RESOURCES FOR EFFORTS

I'm going to read you a list of resources that could be used to address trauma in the COPH community. For each of these, please indicate whether there is **none, a little, some, or a lot** of that resource available in your community that could be used to address trauma..

- Volunteers
- Financial donations
- Grant funding
- Experts
- Space

Would community members and leadership support using these resources to address trauma? Please explain.

Are there community members who oppose or might oppose addressing trauma? How do or will they show their opposition?

Describe the COPH campus community.

LEADERSHIP

Using a scale from 1-10, how much of a concern is trauma awareness, training, and treatment to the leadership of the COPH community, with **1 being "not a concern at all" and 10 being "a very great concern"**?

Can you tell me why it's a [ ]?

How much of a priority is addressing trauma for the leadership of the COPH?

Can you explain why you say this?

On a scale of 1 to 5, where **1 is no effort and 5 is a great effort**, how much effort are community members and/or leadership putting into doing each of the following things to increase the resources going toward addressing trauma awareness, training, and treatment in the COPH community?

- Seeking volunteers for current or future efforts to address trauma in the community.
- Soliciting donations to fund current or expanded community efforts to address trauma.
- Writing grant proposals to obtain funding to address trauma in the community
- Training community members to become experts.
- Recruiting experts to the community.

I'm going to read a list of ways that leadership might show its support or lack of support for efforts to address trauma. Can you please tell me whether **none, a few, some, many, or most** leaders would or do show support in this way? Also, feel free to explain your responses as we move through the list.

How many leaders

- At least passively support efforts without necessarily being active in that support?
- Participate in developing, improving or implementing efforts, for example by being a member of a group that is working toward these efforts?
- Support allocating resources to fund community efforts?
- Play a key role as a leader or driving force in planning, developing, or implementing efforts? *(How do they do that?)*
- Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?

Does anyone in leadership support expanding efforts in the community to address trauma awareness, training, and treatment?
(passive support, developing, or driving force)

Who are the leaders that are supportive of addressing this issue in your community? *(What areas or departments do they tend to congregate in?)*

Are there leaders who might oppose addressing trauma? How do they show their opposition?

Are you aware of any proposals or action plans that have been submitted for funding to address trauma in the COPH community?

Questions

- As far as you know, is trauma education included in the curriculum? What does this education include?
- Do you think students in the COPH graduate prepared to work professionally with traumatized populations?
- Have you received any formal training in trauma or in working in a trauma-informed way? What has that experience been?
- Are there any ideas you have about integrating trauma awareness, training, or treatment into the campus community?

Appendix C

Community Readiness Model Score Card

Community Readiness Model Data Summary

Community Readiness Model Score Card

Dimensions	A	B	M	S	W	H	G	J	C	Average
Knowledge of Resources	6	3	3	3.5	4	2	3.5	3	2.5	**3.4**
Leadership	4	3.5	4	3	3	3.2	4.8	2.5	5	**3.7**
Community Climate	5	3	5	3.5	4	4.5	5	3.5	4	**4.2**
Knowledge of Issue	5	4.5	4.5	3	3.3	3.8	3.5	3.5	4	**3.9**
Resources	3	---	3	2	4	3	3	2.5	3	**2.9**
Average CR Score	**4.6**	**3.5**	**3.9**	**3**	**3.7**	**3.3**	**4**	**3**	**3.7**	**3.6**
Knowledge of Specific Efforts	5	1	1	1	2	1	1.5	2	1	**1.7**
Overall Average CR Score	**4.7**	**3**	**3.4**	**2.7**	**3.4**	**2.9**	**3.5**	**2.8**	**3.25**	**3.3**

Community Readiness Data Summary

Trauma Awareness, Training, & Treatment on the UNMC COPH campus

Community Readiness is the degree to which a community is willing and prepared to take action on an issue. According to the Community Readiness Model (CRM), communities move through nine stages of readiness in preparation for taking action.

How ready is the UNMC COPH community to address psychological trauma?

3.3 **UNMC COPH Total CR score: VAGUE AWARENESS**

3.9 **COMMUNITY KNOWLEDGE OF TRAUMA: VAGUE AWARENESS**

Community members know a little bit about the issue and acknowledge that the issue is of some concern. However, there appears to be little motivation to act; limited resources and efforts are being used to address the issue.

4.2 **COMMUNITY CLIMATE: PRE-PLANNING**

Community members know a little bit about the issue and show a fair amount of concern for the issue when it arises. However, few resources and efforts are being used to directly and proactively address the issue.

3.7 **LEADERSHIP: VAGUE AWARENESS**

Some members of leadership have knowledge of the issue and acknowledge it is a concern when it arises. However, few resources and efforts are being used to directly and proactively address the issue.

2.9 **RESOURCES: DENIAL/RESISTANCE**

Community members know little about the scope or impact of the issue. There are misconceptions about the issue and no firm agreement that resources should be used to directly and proactively address the issue.

2.9 **COMMUNITY KNOWLEDGE OF MENTAL HEALTH RESOURCES: VAGUE AWARENESS**

What community members know about available resources ranges from very little to a lot, with most community members knowing little. There is a prevailing sense that the issue is important, but no immediacy or urgency about developing or promoting more resources.

1.7 **COMMUNITY KNOWLEDGE OF SPECIFIC MENTAL HEALTH EFFORTS: DENIAL/RESISTANCE**

The majority of community members know little or nothing about specific mental health resources that may address trauma. There is a sense that the issue is not enough of a concern to address directly and proactively.

9 Stages of the Path to Readiness

1. No Awareness: *What is trauma? That's not an issue around here.*

2. Denial/Resistance: *I don't know anything about trauma. I don't think it's really a problem.*

3. Vague Awareness: *I know a little bit about trauma and I think it's a problem. But I'm not really sure anything's being done about it and I don't know what can be done.*

4. Pre-planning: *I think trauma is an issue that needs to be addressed. There's nothing specific that we're doing, but here's how we address it when a problem arises.*

5. Preparation: *We are concerned about this issue and need to take steps to address trauma now. We have identified funding sources and we're developing interventions.*

6. Initiation: *Trauma is a critical issue in our community and it's our responsibility to address it. We have X and Y in place and are working to develop several resources.*

7. Stabilization: *We have taken responsibility for addressing trauma in our community and we are working to ensure that there will be ongoing support and resources to support our efforts.*

8. Confirmation/Expansion: *We know a lot about how trauma manifests and impacts our community. We are continuing our work to support ongoing efforts to address trauma and implement new ones.*

9. Community Ownership: *We are committed to proactively addressing the issue of trauma in our community. We continuously evaluate and work to sustain ongoing efforts to address this issue. We also seek to evolve our programs and knowledge.*

https://tec.colostate.edu/wp-content/uploads/2018/04/CR_Handbook_8-3-15.pdf

Appendix D

Community Readiness Campus Report

(separate PDF attachment)

Spotlight on Mental Health:
An assessment of trauma awareness, training, & treatment in the UNMC COPH campus community

A Capstone Project in fulfillment of the MPH by Jenny E. Mueller, Department of Health Promotion

23.5% of U.S. adults report experiencing 2-3 Adverse Childhood Experiences;
17.3% report 4 or more ACEs
(CDC, 2023)

"What really stands out to me about ACEs...is that ACE research is about 0-18, but a lot of ACEs continue to exist, not just within the person, but in the family unit, beyond the age of 18."
(Faculty)

Before the pandemic, over half of graduate students reported high stress levels, up to 40% of graduate students suffered from anxiety and depression, and over one third of doctoral students sought help for anxiety and depression. Recent studies of students indicate that levels of anxiety or depression have increased by approximately 10% during the pandemic."
(Gowen et al., 2023)

A misconception about trauma is "That trauma is something we study in other populations and not something that affects our population of students, or particularly of faculty and staff."
(Staff)

"there is a dearth of research related to the potential for trauma work to impact members of the academe"
(Nikischer, 2019)

"Well, one area that I find that we are not talking about that concerns me is vicarious trauma."
(Staff)

"We should recognize that people's experiences they may not have to deal with on a regular basis may come up when they get into a classroom setting..."
(Staff)

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