



Center for Child and Family Traumatic Stress  
at Kennedy Krieger Institute

# TRAUMATIC STRESS CHRONICLES

GROWTH THROUGH TREATMENT, TRAINING, AND RESEARCH

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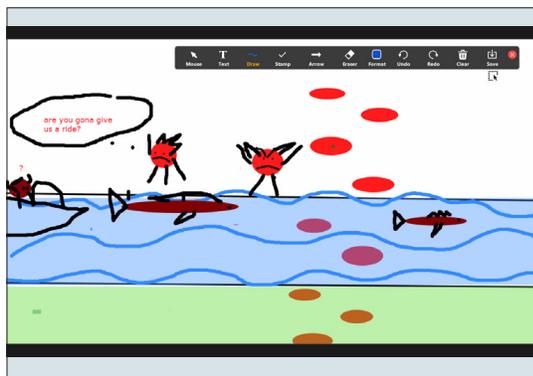
Pandemic fails to interrupt community support and services from NAMI Metropolitan Baltimore

### INTERVENTION INSIGHTS

## EVIDENCE-BASED THERAPIES VIA TELEHEALTH: ADAPTATIONS, CHALLENGES, AND LESSONS

Prior to the onset of the COVID-19 pandemic, families receiving mental health services at the Center for Child and Family Traumatic Stress were accustomed to being greeted by staff and invited to play games or color while waiting for their session to start. Kids often ran out of their session carrying a craft made with their therapist as they learned about relaxation and coping. Before leaving, parents would have to make a final important decision about their child: would they like Goldfish or graham crackers? During the last two years of virtual interactions, the children and families have taught us empathy, patience...and that AirPods headphones will hang up a Zoom call if not carefully handled when you put them in your ears!

Many changes come to mind when we think about the adaptations that we have made as therapists to provide evidence-based treatments via telehealth. We have adapted



**A nine-year-old boy in telehealth sessions of TF-CBT showed why he avoids talking about his trauma history: Adults are barracudas who might help or hurt you.**

assessment tools to electronic versions, made use of therapeutic books read on video, and become masters at engaging in play from behind a screen. While we as therapists are strategizing ways to use headphones and online worksheets to hold fidelity within a treatment model, we have come to realize that many of our clients are impacted most by the less formal parts of therapy.

We have faced real challenges in our efforts to keep families engaged and meet their unique needs through telehealth. But

we also discovered amazing benefits. We have adapted how we work with children under the age of five, and with those enrolled in Parent Child Interaction Therapy (PCIT) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). We have even brought our families together for virtual dinners as part of Strengthening Family Coping Resources (SFCR), a multifamily group. Here is a closer look at our adaptations to these evidence-based therapies as we have evolved to telehealth.

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## DIRECTOR'S CORNER



The content of our Winter 2022 edition focuses on some of the strategies used here at the Center for Child and Family Traumatic Stress during the past 2+ years to help our staff and the families we serve to adapt to the COVID-19 pandemic. We have also been aware that many are simultaneously dealing with the pandemics of structural racism and increased mental health challenges. This phenomenon is best described by the word syndemic – defined by the Centers for Disease Control and Prevention as “synergistically interacting epidemics.”

An approach to understanding and reducing the negative impacts of these conditions focuses on the adverse interactions between them and the social, political, and economic situations in which they co-occur. Our October 2021 Trauma Conference offered policy, social justice, and mental health practices designed for individuals, families, and communities dealing with these conditions.

In our efforts to “walk the talk” as we try to do our part in ameliorating some of the negative effects of this syndemic, we have made a commitment to expand our concept of service to others and enhance our internal capacity. We understand that for many populations, trauma and social injustice are inexorably linked. In addition to providing traditional treatment approaches, we are actively looking for ways to advocate with and for groups that, based on race, sexual orientation, immigration status, economic status, ability status, etc., have been historically ignored and are currently under-resourced. Further, the Traumatic Stress Center, along with our Therapeutic Foster Care and Early Head Start programs, is actively working on becoming anti-racist. Facilitated open dialogue, all-staff training, individual and group coaching, book clubs, and affinity group discussions are some of the strategies we have engaged in so far in the early stages of the journey. Believing we are in it for the long haul, we have built accountability and sustainability into our process as we make decisions about next steps.

Finally, this syndemic has impacted clients, our community partners, as well as our staff. We fully recognize the value of our staff as individuals who are balancing their own personal lives with the mission-driven work that we engage in. Remote work has its positives as well as negatives, as we make clear in this newsletter’s stories. Fostering employee well-being and a culture of collective commitment has been operationalized as we work toward achieving metrics and milestones that will get us closer to what an optimal work environment might be.

Sincerely,

■ **Elizabeth A. Thompson, PhD**

Meet our first-time contributors to *Traumatic Stress Chronicles*! **Angela Celano, LCSW-C**, is a clinical social worker at the Traumatic Stress Center. **Teresa Loya, LCSW-C**, is the coordinator of the Center’s PCIT Clinic. **Gabriela Renderos, LCSW-C**, is a bilingual social work therapist at the Center, and **Miguel Roberts, PhD**, is Faculty/Training Coordinator at the Training Academy and a clinical psychologist at the Center’s Mental Health Outpatient Program. You’ll find their writings in our *Intervention Insights* column on EBT adaptations and *Training Front* story on the 8th Biennial Trauma Conference.

## TRAINING FRONT

# OUR 8<sup>TH</sup> BIENNIAL TRAUMA CONFERENCE: HOW WE WENT VIRTUAL BUT STAYED “REAL”

In March 2020, COVID-19 led to the mass cancellation of professional conferences, and to rapid decision-making on the part of conference organizers. At the Center for Child and Family Traumatic Stress, our Training Academy changed many activities to a virtual platform, including a series of monthly hour-long events in the summer of 2020. However, that fall, as we looked ahead to our 8th Biennial Trauma Conference scheduled for October 2021, the planning committee faced a difficult choice: do we have an in-person event, do we cancel the conference, or do we change to a virtual format. And if we hold a virtual conference, can we provide a “real” conference experience?



At the time, the prospect of a COVID-19 vaccine was not certain. We surveyed the profession and could find no organizations holding in-person events. Pro sports were taking place without audiences present; bars and restaurants were still closed or offering takeout only. It seemed clear that if we were going to have a conference, it would have to be a virtual event.

We saw the advantages of a virtual conference. We could recruit speakers nationwide, without concern for the added expense of travel, per diem, and hotels. We would be able to market

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## FROM SPRINT TO MARATHON, STAYING THE COURSE THROUGH PANDEMIC UNCERTAINTIES

In March of 2020, as families were canceling sessions during COVID-19's first surge, our clinical and care teams at the Center for Child and Family Traumatic Stress immediately rose to the challenge. We switched to telephonic or video-based sessions faster than we could read through the instructions. A whirlwind of adjustments followed as we built skills and processed new information. We never actually closed down the clinic, although most staff and trainees began working remotely, setting up work spaces in houses, apartments, and rented rooms. We quickly moved our training activities to a Zoom format.

We thought this would all be short-lived.

From the beginning, we did a lot to support staff and stay in touch. Many of us felt the daily stress of caring for children and elderly or medically fragile family members while providing support to clients. Many of the families we work with are those who have been disproportionately affected by COVID; in weekly sessions, clinicians bore witness to their suffering while experiencing their own losses and setbacks. It was easy to see that therapists and clients were experiencing a shared trauma. But we also demonstrated creativity, flexibility, endurance, and a sense of teamwork.

We used staff-wide emails to provide supportive tips and tools, along with updates about how well our team was doing at maintaining clinical services. We knew that even younger staff and trainees quickly felt the aches and pains of prolonged Zoom work in home "offices." Yet, our long-standing clinic and other meetings continued without fail. They provided social support and opportunities to learn new ways of delivering services – but also contributed to Zoom fatigue and feelings of isolation and alienation! We threw baby showers and farewell parties. We prepared slide shows, played games, and attended a remote "retreat." Seeing the children and pets of staff on Zoom brought enjoyment and diversion. We encouraged people to take time off even though there was nowhere to go.

Somewhere along the way, we shifted from a sprint to a marathon. We felt hope, maybe tinged with anxiety, and had some differences of opinion about public health policies relating to vaccines. In May of 2021, there was a wonderful marrying of spring's arrival with declining COVID infection rates. However, the virus again loomed

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I miss the chance hallway conversations that make me laugh, help me feel connected and help me see things in a different way. Zoom just isn't the same but it is better than no contact! I have felt very lucky to have the flexibility to work at home or work at the office. I have been able to provide for my family and meet some of my professional goals at the same time.

– A STAFF MEMBER FROM THE TRAUMATIC STRESS CENTER

I am raising my two teenage daughters on my own. I work full-time nights and go to school part-time. They need their sessions and I need the family therapy sessions. Some days I am too tired to get on yet another Zoom call but I always feel better afterwards. It's not quite the same as in person, but we have been able to attend our sessions very regularly throughout the pandemic. This has helped me with my stress and my daughters with theirs. We are all doing great in school!

– A FAMILY MEMBER FROM THE TRAUMATIC STRESS CENTER



Staff members at our brick-and-mortar Center mid-pandemic: (L-R) Yolanda Scovens, Dee Dunston, and Jennifer Serico.



A Friday Zoom Lunch takes place with the Center's Betsy Offermann (on screen) and Emily Driscoll-Roe.

# NATIONAL ALLIANCE ON MENTAL ILLNESS SERVES AS CRITICAL STOPGAP FOR PANDEMIC-STRESSED BALTIMORE



Kerry Graves, Executive Director of NAMI Metropolitan Baltimore.

**The National Alliance on Mental Illness is a grassroots nonprofit organization that for more than 35 years has provided support, education, and resources to people and families living with mental illness. NAMI Metropolitan Baltimore chapter provided more than 8,500 touch points of service to people in the Baltimore area in 2020. As the pandemic persists, NAMI's reach has grown and become more critical in reducing isolation and acting as a stopgap for people in need of mental health treatment and education but with limited access to services. The Center for Child and Family Traumatic Stress has been privileged to be part of NAMI's Ending the Silence educational seminars during the pandemic to help families seeking information and support. I had the opportunity to speak with Kerry Graves, Executive Director of NAMI Metropolitan Baltimore, to further explore NAMI's impact on our community during the pandemic.**

**It seems that the theme in our field during this pandemic is all about growing, changing, pivoting. How has NAMI Metro Baltimore adapted to continue to provide support?**

*Kerry Graves:* This has been so incredibly challenging and I am so proud of my staff. I'll say that up front. I am so proud of the way they've responded to this pandemic throughout. The entire time. We had support groups up and running within two weeks of closing our office. We were one of the first NAMI affiliates across the country to get them running, so we were able to serve as a role model for other affiliates on how to do it and best practices. Every single one of our programs was launched online over the last year or so. There is nothing that was on our menu of services prior to the pandemic that we aren't continuing to do, and doing even more of.

**What commonalities have you seen among the people who have reached out to NAMI since COVID?**

*Kerry:* I think there are individuals who perhaps had a mental health condition that they were managing well prior to the pandemic, but this has really been a sort of that pushing point of 'Oh, I really do need some help.' And then there are family members who have spent more time in the house together and started to realize, 'Oh, I'm seeing signs of a mental health condition that I didn't see before I was spending this much time with my child or my significant other.' And we definitely have seen that curiosity factor – people thinking, 'Is this something we should be seeking treatment for?' But we saw so many individuals who knew about their mental health condition, and they were managing well, and the pandemic has just exasperated them. So now they are reaching out and finding that they do need that extra peer support.

**You wrote on your website that offering your support groups and trainings through Zoom was great because it increased the number of people who were able to access them – but that some participants who were really engaged with you before the pandemic didn't really engage over that modality. How do you explain that?**

*Kerry:* One of the blessings of this technology is that it removes that transportation barrier. People don't have to travel to the meetings, they can hop online, so it was certainly more accessible to individuals who have access to the technology. But then there are individuals who do not have access and that is a whole other barrier.

We saw brand new faces in our support groups throughout this time and some individuals love the online format and are just thrilled that we're offering this. They can log into their Baltimore support groups from elsewhere or from the comfort of their home. However, the part that was taken away by using technology is the participants'



Source: NAMI Metro Baltimore 2021 Annual Report

feelings of privacy. In our support groups, we are very careful to say that all the information shared is confidential. And we were very concerned at the beginning of the pandemic, when we launched the online groups, about how we would maintain that confidentiality, and we put measures in place. Support groups were drop-in when they were in person. Now you have to register in advance for virtual groups so that we know who is present. We've got a virtual waiting room so we can pull

people out if we need to in the middle of a group if it doesn't seem like they're in the right spot. But with the pandemic, if we are all at home and if I live with five other family members, finding a space where I feel safe enough to speak can be incredibly hard, and maybe it would have been easier for me to just leave the house and go to a support group and know that I've got a confidential space. So there are pluses and minuses to both.

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## ...NATIONAL ALLIANCE ON MENTAL ILLNESS

It's come to a point where people are taking some really deep breaths and thinking about what they can handle. The pandemic has caused people to access help at rates never before seen, to the point where providers are overwhelmed with calls for help. But NAMI keeps people connected as they wait for services for twice and three times as long as they might have before the pandemic. How does NAMI do this?

*Kerry:* We operate a rapid referral program that better connects providers to our services. The providers send us names of individuals who have released their names, and then we will connect with those individuals to get them into our support groups and programs. We're hearing from providers that, pre-pandemic, we were considered a supplemental service. Now, we are seen as sort of that stopgap, where providers with wait lists that are months long are saying 'go to NAMI in the meantime, join their support group, get the peer support so you've got something until you can get your clinical services.' We just relaunched our in-person support groups and we have a few individuals who were coming online who started coming in person, so we're seeing different faces. We're seeing those people that came online continuing to come online, and new individuals coming



The Center for Child and Family Traumatic Stress has been part of NAMI Metro Baltimore's Ending the Silence educational seminars during the COVID pandemic.

online. That says to us that we're on the right track. We are adamant that we're going to do both of those models of support and classes because it's really responding to that community need.

\* \* \*

If you or someone you know is living with a mental illness and needs support and education, NAMI can help. Call NAMI Metropolitan Baltimore at (410) 435-2600 or visit [namibaltimore.org](http://namibaltimore.org).

■ **Emily Driscoll-Roe, LCSW-C**

## ...STAYING THE COURSE THROUGH PANDEMIC UNCERTAINTIES



Adopt-a-Family for the Holidays participants Irene Mutitu (L) and Dee Dunston.

large as we neared the start of a third school year affected by the pandemic. Our clinicians re-scrambled to accommodate the needs of families and their freshly complicated schedules. Staff members who are also parents tackled a new set of work-life challenges. As summer turned to fall, we focused on preparing for an increase in on-site activity. We had started to make slow and steady progress, knowing that winter could be tough and our onsite activity might dwindle. We weren't anticipating such a highly transmissible new variant.

Throughout these two years there have been deaths, truncated mourning, lost jobs, financial stress, disrupted educational plans, loss of ability to work, illnesses, and important milestones, some of them missed. Yet our team rallied through every round of adjustment and adaptation, every cycle of the raising and lowering of hope. Ours is a

highly mission-focused group. We all come to this work for different reasons, but our common purpose is the mission. It holds our focus and demands that we keep returning to the tasks at hand, session by session and meeting by meeting. From sharing tech and clinical resources, to finding humor on Zoom calls, to encouraging one another to find moments of rest and enjoyment, there are many examples of looking after each other. I can't predict what will be happening with COVID or any of the other threats we face by the time this newsletter is published. However, I am confident that if we stay flexible, push back against isolation, and adapt our thinking, approaches, systems, and services...we will be OK.

■ **Sarah A. Gardner, LCSW-C**

(Photos pages 3 and 5 courtesy of Sarah A. Gardner)

## ...ADAPTATIONS TO EVIDENCE-BASED THERAPIES

### EARLY INTERVENTION: CHILDREN AGES ZERO THROUGH FIVE

Young children attending therapy at the Traumatic Stress Center often are enrolled in PCIT, TF-CBT, or Child-Parent Psychotherapy. Others are enrolled in family therapy based on theoretical understandings of attachment and family systems to address trauma symptoms. Regardless of the type of therapy they are receiving, we have made many adaptations in order for telehealth to be successful with young children.

We allow for flexibility in caregiver engagement. This may mean that adults-only discussions happen in another room while the child watches TV, or in their car parked in front of the house, or via the chat function in Zoom. We have diversified play options to increase interaction between participants; while older children might engage in an online game, younger children often require a more creative form of play. We might help a caregiver make paper dolls to represent family members, play interactive games like “Peek-a-Boo” and “I Spy,” or prepare toys that match what the child has at home so we can play parallel through the screen.

We have also increased our focus on sensory regulation. Some therapists use stretch or dance breaks to help children and caregivers regulate their bodies during this time when screen-fatigue is becoming more common. Children under three often need more adult supported sensory activities to help them maintain focus and regulation. One of our children shouts “Burrito game!” when she senses her need for a break. The caregiver rolls her up in a blanket and the child laughs as she unrolls herself.

We have observed clear benefits from use of telehealth. Our clients give more focus to using tools and skills available to the child and family in their own environment. The need for adult supervision during sessions has created a natural emphasis on attachment and attunement, which are primary components of all treatments for young children. Families are comfortable, and they are able to access snacks, diapers, and other items to make their time in therapy easier.



### PARENT CHILD INTERACTION THERAPY

PCIT is an evidence-based treatment for children ages 2 to 7 who are exhibiting problematic behavior. For the past 15 years, we have been using this live-coaching model to help build relationships and change the trajectory for young children and their families. In the office we use a controlled environment designed to ensure safety and set a family up for success. During remote sessions, our ability to manage the client’s environment is obviously limited, resulting in challenges and growth opportunities for families and clinicians alike.

The challenges came in the areas of technology access, resource limitations, and variable home environments. We began to address tech limitations by sending Bluetooth headsets, tablets, and hotspots to families as needed. To orient and train families on use of technology we used videos shared in the national PCIT community, and shared what worked in our weekly team meetings. Resource limitations include space, access to toys, and often, parental energy. We attempted to provide increased support by showing caregivers how to work with what they had, creating and sharing a list of no-cost or low-cost play activities; and we eventually developed a plan to provide age-specific toy kits to all families at the start of treatment. Families are amazing problem solvers and know their own spaces best, so we worked with them wherever they were: seated in living rooms and hallways, playing on kitchen tables and beds, and finding somewhere new every day. To address the energy deficit, we learned how



to turn up the volume and share some of our own energy with depleted caregivers.

Almost immediately, we identified the need to extend our early treatment sessions to acknowledge and incorporate the unique needs of the home setting. We discuss space, privacy, toy choice, and parent comfort. We recognize the role of other adults in the home and discuss how they may support or create challenges with sessions. Additional session time has been added in both child- and parent-directed interaction components to talk in depth about what pieces of the treatment protocol might compromise safety. In situations where we have identified at-risk clients or dangerous settings, we encourage the client to wait for in-office services.

The most pronounced benefit is that telehealth gives us the opportunity to join the child and family where their interactions are most typical – at home. It reassures caregivers that we really understand their experience: “There! Now you see it! That is what he always does. Looks then pretends he doesn’t hear me.” The virtual interactions keep us grounded in the realities of the stressors and strengths our families experience in their homes, and has strengthened the way we explore family culture to support effective intervention.

### STRENGTHENING FAMILY COPING RESOURCES

SFCR brings together families living in traumatic contexts to help both children and caregivers reduce posttraumatic stress symptoms. It is rooted in the awareness that routines and rituals can be disrupted by stress and trauma. Over the past decade we have cultivated a welcoming space for our SFCR multifamily groups. When the pandemic began, the task of creating a virtual version of this space felt daunting at first. Luckily the SFCR curriculum had already been adapted for caregiver-only groups, so we quickly converted our in-person multifamily group of almost 40 adults and children into a virtual caregiver-only, adults-only group. This allowed us to continue to provide support to caregivers who had already completed 4 weeks of our 15-week session, and who were navigating

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## ...ADAPTATIONS TO EVIDENCE-BASED THERAPIES

increased pandemic-related stress. As schools shifted to virtual learning and many caregivers added “teacher” to their growing list of roles, these groups helped them work together to develop all new household routines to support at-home learning. The caregiver groups, and later the multifamily virtual groups, countered trauma-related isolation and disconnection, which the pandemic exacerbated. They became a source of support that, a caregiver noted, helped them realize they were “not alone” and gave them a “sense of belonging.”

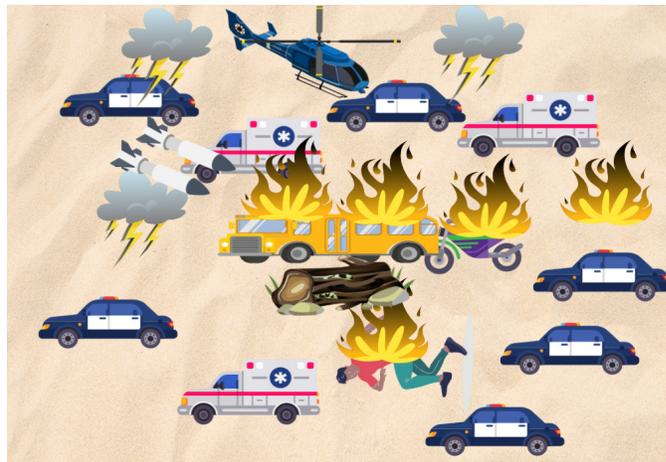
During the winter of 2020, our thoughts turned to holiday rituals and traditions involving connection with extended family members and joining in community over meals – which was complicated in a socially distanced world. We held a booster session on Zoom with families who had previously completed the SFCR multifamily group together; and although we could not share a meal in person, we delivered boxed dinners and art supplies so the families could create connections, adapt old family traditions, and create new rituals. Through the creativity and dedication of our therapists and collaboration with SFCR and its organizations across the country adapting SFCR for telehealth, we have now run the SFCR caregiver group and the multifamily group virtually in English and Spanish. Many activities translated easily to telehealth. We used YouTube videos of stories like *Harold and the Purple Crayon* to teach children problem solving. We were even able to send home plants, which we see as a metaphor for family life: the roots of the plant grow together and influence each other, just like families and groups, and need care and nurturing, just like families and groups. Although we could not plant a group garden together, we created a virtual group garden with images of flowers chosen by each family to represent who they are.

Challenging times like this ongoing pandemic require increased effort to notice the positives and find reasons to celebrate, which is always the final activity of SFCR groups. We were delighted at the end of a recent group to hear that the positive energy our therapists always bring had translated to the virtual setting, as a caregiver remarked that she “could feel the good energy through the screen.” Although we could not decorate the room with streamers, we could still share music and laughter, which provided an important reminder for both families and staff that joy and celebration are powerful in the face of stress and trauma.



### TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY

TF-CBT is an evidence-based treatment for children ages 4 to 18 years old who are experiencing trauma symptoms after a traumatic event. Clients and their families work their way through various components building skills to help them relax, practice mindfulness, express and regulate their emotions, and challenge cognitive distortions. These skills help prepare the client to write a detailed narrative of their traumatic experiences, that is later shared with a trusted caregiver. Gradual desensitization during treatment sessions helps to build the client’s capacity to discuss this history.



With an online sand tray and virtual control of the therapist’s mouse, a six-year-old boy with speech and reading difficulties responded to the prompt, “What will it be like to start your new school?”

Doing this very challenging work effectively in a virtual setting has required families and providers to make multiple adaptations.

- We verify whether clients have adequate privacy to work on their trauma narrative. Families have adapted to using the chat feature on Zoom to communicate with us when they do not have adequate privacy; and writing portions of their trauma narrative.
- We ensure that trauma narrative documents are kept confidential and private in a virtual space. The client can use the “share” function on Zoom to show documents privately.
- We rely more on our clients’ ability to communicate their levels of distress or discomfort. In person, nonverbal cues and body language help us discern distress; Zoom calls at most only show a client’s expression and posture.
- Our clients use SUDs (subjective units of distress scales) to communicate their distress level, and can use the emoji reactions feature on Zoom to indicate if they need a break.
- The cognitive coping component can be especially challenging with younger children. We explore ways to keep them physically active and moving around in session to sustain their attention and engagement. We help them differentiate thoughts, feelings, and behaviors by having them move to different spots in the room representing each part of the CBT triangle.

Clients often enjoy utilizing the whiteboard feature on Zoom for affect regulation or drawing pictures that can be added to their trauma narrative. They can use the annotate feature to complete worksheets shared by the provider, while providers can share videos and digital content to enhance treatment. Providers also share these resources in clinic meetings. Clients have said they appreciate having sessions at home where their “comfort items” are easily accessible. And they like not spending time commuting to therapy.

■ **Angela Celano, LCSW-C; Sara R. Davis, LCSW-C; Teresa Loya, LCSW-C; and Gabriela Renderos, LCSW-C**

## ...8<sup>TH</sup> BIENNIAL TRAUMA CONFERENCE

our conference beyond our geographic area since attendees wouldn't have to worry about travel. Our hope was that a virtual conference would be more accessible to a broader and more inclusive audience.

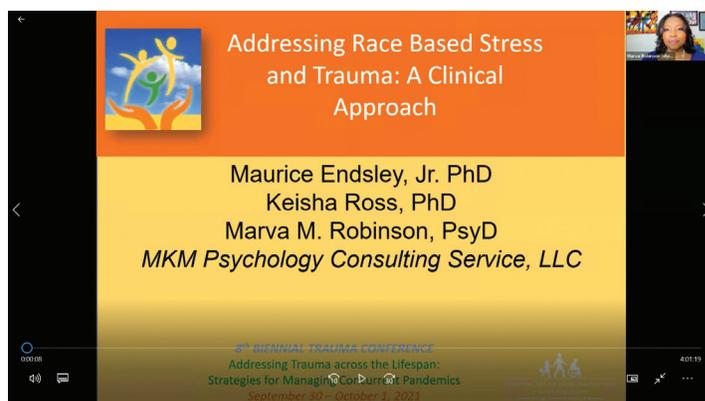
We also acknowledged the limitations of a virtual conference. It wouldn't allow for networking in the same way as an in-person conference. Audience engagement is different in virtual conferences, where emails and other work reminders pull attention away from the conference. Also, we were unsure if the professional community would be tired of virtual events (so-called "Zoom fatigue") by the time the conference came around.

Having weighed these factors, we made the final decision to move forward with the conference as a virtual event. We also decided to change the conference schedule to one of invited speakers and a single stream of plenary sessions (rather than the concurrent sessions we'd done in previous conferences). The pre-conference day would include intensive three- to four-hour workshops consistent with the conference theme; and the conference day would include an opening keynote address followed by 90-minute presentations and a closing panel of organizational leaders.

Choosing a conference streaming platform was another major decision point. In our experiences attending other virtual conferences, we found that some platforms felt like a longer version of Zoom meetings. That was not the type of conference experience we wanted to provide. In November 2020, we decided to use the Cvent virtual conference platform. It allows attendees to enter a Web-based event hub for program information. They can see what sessions are currently live, and join directly from the hub. They can ask questions and respond to session polls (including CEU polls). They can access session handouts, slides, and other materials in a central repository. The platform also offered a screen view that was more focused on the presenters themselves, not on everyone who dialed in, but still allowed for audience interaction and questions.

In December 2020, we finalized our conference theme: the impact of the concurrent pandemics on mental health, with special attention to systemic racism and the disproportionate impact of COVID on Communities of Color. In the following months we were able to secure presenters from our own geographic region (e.g., Baltimore, University of Maryland, Richmond), but also from the Midwest (St. Louis, Chicago, Ann Arbor), the South (Durham, Atlanta), and New England.

After the conference, attendees told us that the content was strong and the virtual format worked. But not everything went smoothly. One of the most common pieces of feedback was about the use



A screenshot of a presentation at the 8th Biennial Trauma Conference shows Dr. Marva Robinson introducing her talk, *Addressing Race Based Stress and Trauma: A Clinical Approach*.

of attendance verification codes required by our CEU approving authorities. We used two coded messages at the beginning and end of each presentation, which an attendee found "distracting from the presentation." Also, having to keep a Web browser open in order to enter the CEU questions created complexity and confusion for attendees. In hindsight, use of more simplified response options and polling question within the presentation would have been ideal.

Another attendee commented that she wished for opportunities for "networking or posting job openings," like a message board, common at many in-person conferences; and for opportunities to informally talk to the speakers after a presentation. The conference attendee hub, which we built to allow for networking and questions for the presenters, also duplicated the chat function of the presentation. Attendees quickly defaulted to using the chat within the presentation, with one attendee noting that he "enjoyed the chat that went on with other audience members" in this way. So the connections between attendees occurred – it was just different from an in-person event.

Overall, our conference planning committee felt that the decision to have a virtual event was the right one, especially as new COVID-19 variants emerged in the summer and fall of 2021. We definitely learned from this experience, including the need to build in more networking opportunities and to simplify our attendance verification system. We credit the success of the conference to our wonderful presenters, staff, and volunteers, and to our early decision-making. Either in-person or virtually, we hope to see you again in 2023 for our 9th Biennial Trauma Conference.

■ **Miguel Roberts, PhD**

We'd be delighted to hear from you about this newsletter, and about relevant happenings in your own work spaces. Email us at [TSChronicles@KennedyKrieger.org](mailto:TSChronicles@KennedyKrieger.org)