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Eliot Sorel, MD, Founding Editor-in-Chief

Trauma, Resilience, and Healing: Global Perspectives

Eliot SOREL MD
Editor in Chief

Wars, disasters, and traumas regrettably abound in the 21st century, with dire consequences for both individuals' and populations' TOTAL health and the sustainable integrity of planet Earth.

We focused the current issue of our Review on a reflective process regarding these challenges and invited healing solutions. We do so in the spirit of the Hippocratic Oath of our profession – "First do no harm," of innovation, and of global ecumenical traditions. We are most grateful for the splendid scientific contributions from our colleagues across the world, conveying a renewed sense of hope, resilience, and healing.

In this trifecta spirit of healing, innovation, and ecumenical traditions we are delighted also to launch the newest section of our Review, Medicine, Mental Health and the Humanities. We appreciate this new section's intrinsic value and value added as an inspiring platform for resilience promotion and healing as a result of the creative, integrative process among science, medicine, mental health, and the humanities, across generations.

We dedicate this issue of our Review to the nearly two thousand members of the Global Mental Health and Psychiatry Caucus of the American Psychiatric Association (APA). We gratefully acknowledge their steadfast resilience in serving our people in the frontlines of a devastating pandemic and fulfilling the best ideals of the millenia-old medical profession.

We look forward to celebrating the 10th anniversary of the Caucus at the APA Scientific Meeting in New York City this May.

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The Global Mental Health and Psychiatry Review (GMHPR) is a multidisciplinary publication serving the global mental health community. It welcomes original scholarly contributions that focus on research, health systems and services, professional education and training, health policy, and advocacy with a catalytic focus on TOTAL Health"

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Colleagues interested in contributing to future issues should contact our Editor's Virtual Office at gmhpreview@gmail.com, presenting a manuscript proposal for feedback and approval. Submitted manuscripts should have not been published, accepted, or under review elsewhere.

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From Trauma to Triumph: Harnessing Resilience Resources for Well-being

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The universal desire for happiness is deeply ingrained in people. Achieving happiness not only enables people to care for themselves but also extends to their ability to care for others. However, living in an imperfect world presents numerous challenges that can undermine happiness. Loss and suffering are integral aspects of life, whether stemming from the loss of a loved one or a job, or the struggle to overcome illness, abuse, and various other woes. Vulnerable individuals exposed to traumatic experiences often face heightened risks of posttraumatic stress disorder (PTSD) and depressive symptoms characterized by disturbing flashbacks, avoidance or numbing memories of the event, hyper-arousal etc., symptoms that can continue for more than a month after the event[1]. These traumas, that can be as a result of living in war-affected communities, being a victim of terror attacks, natural disasters like hurricanes and earthquakes, instances of sexual abuse, bullying, as well as being an immigrant or refugee, contribute to significant mental health challenges[2-5]. The prevalence of these mental conditions emanating from trauma underscores the pressing need for effective coping mechanisms and support systems. Additionally, such adversities that lead to both physical and emotional injuries coupled with the stress of daily living can disrupt one's sense of safety and introduce a constant threat.

Research indicates that healthy coping from traumatic experiences is not only a possibility but often a feasible response to life's adversities. The ability to rebound from such challenges is linked to how people react in these situations. This individual's ability to adapt to stress and deal with adversity is referred to as psychological resilience. Resilience is found within each individual and can be developed. It is best considered a process rather than a trait —a progression of psychological and physiological adjustments that can be made to better enable an individual to cope with trauma. The human capacity to bounce back is vast, and humans possess a wealth of resilience resources that can be harnessed to navigate life's complexities. Coping with adversity is a shared human experience, and the resilience in bouncing back is shaped by the diverse resources at disposal[6].

Resilience resources encompass various factors that contribute to an individual's ability to navigate challenges and adversities effectively. One factor is mental toughness. Studies suggest that mental toughness can act as a protective factor in the resilience process, moderating the relationship between stress and depressive symptoms. Additionally, self-esteem, reflecting one's self-worth, serves as a protective resource buffering against negative impacts of challenging experiences. Research consistently associates higher self-esteem with greater resilience and overall happiness. Consequently, optimism, defined as holding positive expectations about the future, is linked to proactive responses to adversity and greater persistence towards goals. Research demonstrates its association with better mental and physical health in challenging times thus having protective effects against depression, anxiety, and stress, hence contributing to greater life satisfaction. In addition to these psychological resources, adaptability is highlighted as a crucial factor in resilience. This involves adjusting thoughts, behaviors, and emotions in response to changing circumstances. Tapping into the resilience resources available becomes crucial in fostering individual and collective well-being[7].

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Trauma, Resilience, and Healing: An African Perspective


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Trauma can assume acute, chronic, or complex dimensions but central to trauma is the adverse effect it has on an individual's ability to cope with daily activities and contributions to their communities, invariably their mental health and wellbeing. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, describes trauma as the exposure to actual or threatened death, actual or threatened serious injury, or actual or threatened sexual violence.[1] The World Mental Health Survey in 2017 showed that over 70% of participants experienced at least one traumatic event in their lifetime.[2] Arguably, higher prevalence may be reported if a more recent study were conducted, considering the increase in natural and manmade traumatic events globally. Humans are often confronted with traumatic events throughout their lifespan. Some, more life threatening than others. These experiences may extend beyond immediate distress to long-term consequences. However, not everyone exposed to traumatic events will develop mental disorders. Some individuals may display overt symptoms of posttraumatic stress disorder (PTSD), and depression, some may exhibit subclinical symptoms, while others may develop resilience.[3,4] The impact of a traumatic event on an individual depends on factors such as the individual's characteristics, type and characteristics of the event(s), developmental processes, meaning of the trauma, and sociocultural factors.[4] As the potential for trauma applies to all humans likewise individuals possess the capability for resilience and healing.

Resilience has been variably defined but it is a concept that is shaped by the cultures and experiences of individuals. Generally, resilience is perceived as strength. However, it can be weaponized and used to oppress, marginalize, and trivialize the plight of certain people.[5] Therefore, resilience should not be interpreted outside of context. To fully grasp the concept of resilience with regards to healing it is pertinent to understand how individuals' function within their society during crisis and to understand how a society functions or malfunctions during crisis.

The presentation of traumatic events and symptoms vary, but African collectivist practices have remained mostly constant. The collectivist orientation of African culture which places premium value on maintaining and affirming relationships, family connections and interdependence supports trauma healing and post-traumatic growth among traumatized African communities.

Common western models which have been endorsed for the management of traumatized individuals include cognitive behavioral therapy (CBT), psychodynamic psychotherapy, eye movement desensitization and reprocessing amongst others. Western psychotherapy may be delivered in isolation or in combination with pharmacological and social interventions. Indisputably, these are effective methods which have been demonstrated to aid recovery from trauma and other mental disorders. Notwithstanding, to ensure healing from traumatic events one needs to understand the reality of a society. Africa largely operates a socio-centric society and embraces "ubuntu", the overarching philosophy of African humanism. "Ubuntu" is loosely defined as a people centered approach to viewing the

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world.[6] In the pursuit for a modern panacea for traumatized individuals, western methods were largely adopted to the neglect of efficient traditional African methods. It is plausible that western practices have systematically marginalized indigenous and African healing practices and erased invaluable cultural knowledge,[7] endorsed by concepts such as "best practices" and "evidence-based interventions".

Early accounts of the management of traumatic experiences and illnesses that are now characterized as mental disorders describe African methods such as oral dialogues, narratives, music, traditional, complementary, and alternative medicine amongst others. Talk therapy is an integral part of African civilization and its culture. Anecdotal evidence suggests that the practice of talk therapy or African psychotherapy predates the introduction of Sigmund Freud's "talking cure" in the 19th century. Poor documentation can be considered as an impediment to its universal adoption. In clinical practice, it is not uncommon to consider methods such as cognitive behavioral therapy (CBT), eye movement desensitization and reprocessing (EMDR) for traumatized individuals whereas terms such as " Oriki", "Meseron therapy", "Harmony restoration therapy" are unfamiliar. Indigenous games, music, drama, and narratives which incorporate meditation and restoration of hope are examples of African methods for trauma healing. Appraisals of these methods show similarities with western ones such as Yalom's group psychotherapy. Unfortunately, there are few documentations of their effectiveness. Empirical evidence from a tertiary health institution in Nigeria which uses indigenous methods for trauma healing shows promising outcomes. Consequently, there is the need for extensive research on the effectiveness, improved documentation, and adoption of African treatment modalities for resilience and trauma healing.

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Moral Injury, Trauma, and Distress:
An Ethical View Of Mental Health Research

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It does not need much thought to recognize that classical texts on moral philosophy deal with matters we now consider falling within the wide spectrum of psychiatry and mental health[1]

The term *'moral injury'* refers to the lasting psychological, biological, spiritual, behavioral, and social impact of perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations. Although moral injury is currently not an accepted diagnostic labelling it is worth examining its relevance to prevention, promotion, and treatment in clinical and epidemiological contexts.

The link between mental illness and moral injury was suggested in the 1990s by Jonathan Shay, a psychiatrist at the Department of Veterans Affairs in Boston, Massachusetts when attempting to explain the enduring nature of PTSD suffered by US veterans of the Vietnam War[2].

As a concept, moral injury falls between ethics, philosophy of mind, epistemology, and social psychology. The clinical interpretation of moral injury runs the risk of medicalizing ethical behavior associated with distress. However, it reestablishes the profound connection between morality and mental health, as emphasized by the French alienists of the 19th century, who developed the so-called "moral treatment" for mental derangement or disorder.

Because it relates to ethical behavior, the meaning attached to events and perceptions of the self, moral philosophy, and spirituality could add a material dimension to treatments and prevention.

The phenomenon arises from a significant dissonance between experiences and the individual's belief system and worldview. Although a traumatic event is regarded as the primary cause of PTSD, research may show that it occupies a secondary role in moral injury because the latter is driven by an evaluation of the self and the ideal morality of his/her cultural background. The dissonance between experiences and self-concept is not only cognitive. It implies a dissociation between "accepted" emotions and role expectations.

People exposed to situations that produce shame or guilt, and the commonly associated sense of incapacity to deal with their impact on personal beliefs or self-image need not only empathy on the part of healers and helping professionals. It also reminds practitioners of the profound link between culture, behavior, and distress symptomatology. It affects military personnel obliged to perform acts that contradict religious values, migrants who confront alienating demands from a different culture and language, and persons who encounter injustice or deprivation in their daily life (e.g. racism, discrimination, and exclusion)[3,4].

Moral injury might be considered an umbrella term, or a syndrome, characterized by guilt, shame, intrusive thoughts, and self-condemnation. It is not difficult to suspect an association with obsessions, compulsions, distress, violence, and even self-harm.

To experience shame, people have to feel that they have fallen short of a code of behavior that they had set for themselves exposing them to social disapproval or condemnation. To experience guilt, people compare what they consider good moral behavior and their deeds or attitudes. Shame is associated with group beliefs, guilt with contradictions between the ideal self and real experience.

In times of sociopolitical turmoil, fight for rights and against oppression, and justified or unjustified wars, attention should be devoted not only to accepted categories in medical psychiatry. It requires a reflection on social, cultural, and moral determinants of wellness. This is a more encompassing term for health since not only reflects what happens in the present or brings reminiscences of the past. It includes hope and expectations of what the future might bring. Future implies the possibility of the election of courses of action curtailed by current experiences, restricting the horizon of expectations and hope.

It may be observed that moral injury (as opposed to *well-being*) includes a sentiment of despair and may lead to self-destructive behaviors (e.g. suicide) and to rage and anger against others (e.g. terrorist acts, delinquency, and aggression). The link between ethics and psychiatry is a very strong one[5].

Addressing moral injury in the context of PTSD, obsessive compulsive disorder, anxiety disorders, and even psychotic breakdowns might aid in a better understanding of personal and social consequences of traumatic experiences, both acute and chronic, and enhance perception on the part of practitioners that psychiatry is not only a medical specialty but a specialized profession[6] that attempts to understand human beings integrally.

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Containment – Compassion – Consensus

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The October 7, 2023, Hamas attack on Israel and the subsequent Israeli counter-offensive precipitated a major shift in focus for the American Psychiatric Association's (APA) Global Mental Health and Psychiatry Caucus (GMHPC) and a new challenge for me (Dr. Rahn Bailey), current Chair of the Caucus. How could the Caucus best pursue its mission of global mental health education, research, advocacy, and treatment by responding effectively to such an urgent, divisive, and deadly mass disaster? How should the Caucus address a long-standing, historically traumatic conflict, when members of the American Psychiatric Association (APA) stood on both sides of such a polarizing issue?

During the ensuing months, the GMHPC served as a space for sharing ideas, discussion, debate, cathartic release, and some reconciliation. While there were times of contentious debate within the GMHPC community forum, there was also a strong sense of community, as members were quick to support one another's attempts to navigate this emotional time in their personal and professional lives. The Caucus leadership felt that these passionate discussions were an inevitable and necessary part of the process—creating a path forward towards the consensus that would be needed for effective group action.

Engaging the members of the GMHPC was necessary to create practical tools and applications for educational, advisory, and treatment efforts during the prolonged humanitarian crisis associated with the conflict in Gaza[1]. Three Work Groups were established to focus on these initiatives.

1. Work Group 1: Develop position statement(s) on the Israel-Hamas War for the APA.
2. Work Group 2: Develop recommendations and strategies to aid in the provision of telehealth and other services to affected populations.
3. Work Group 3: Develop non-partisan statements and historical narratives regarding the conflict.

In December of 2023, the three new Work Groups began to meet. One urgent initial action step was to develop position statements that could be used by the APA and other medical and mental health organizations in their responses to the Israel-Hamas War.

I (Dr. Patricia Gerbarg) was among the many APA members who felt compelled to find ways to help mitigate the mass disaster that was mushrooming in Gaza and Israel[1]. Serving as Scribe for Work Group-1 (WG-1) and shaping the messages to be sent out from the APA could influence public opinion and government policy. However, to complete our mission, we would have to contend with the conflicts already reverberating within the GMHPC. Dr. Bailey and I worked to maintain a safe holding environment, a framework that could support the discussion of difficult topics with empathy and integrity, as articulated in the George Washington University plan for Strengthening Our Community in Challenging Times[2].

In WG-1, our challenges began when only four of the seven members appeared at our first meeting. No one of Arab ethnicity came. How could the group be inclusive and fairly consider the diversity of viewpoints with no Arab voices? We reached out to members of the larger GMHPC, who had articulated the feelings and needs of Palestinians, to engage them in our small Work Group writing process. Their input was invaluable.

As the agonizing plight of the Gazan refugees worsened, multinational APA members joined those of Arab ethnicities in demanding immediate cessation of all hostilities. Pressure mounted on WG-1 to complete the APA statement quickly. Conflicting messages bombarded us about what it should say along with complaints about the inadequacy of making public statements when thousands of children were dying. Fortunately, calming messages about civility, compassion, and inclusiveness helped to cool and contain the debate.

Tensions arose between expressing the urgency, the cruelty, the inhumanity of the war versus warnings not to assign blame or be insensitive to the deep-seated feelings, beliefs, and histories of both sides. Some members threatened to leave the APA, some felt threatened and chose to write to us privately, others gave support and encouragement. The roles of Caucus Chair and Scribe metamorphosed into negotiator-integrator-container as the group wrestled over words and phrases. Another dilemma arose. How could we forge a strong, impactful statement that would honor our Hippocratic Oath, Primum non nocere (First, do no harm.)[3] meaning, in this context, to not hurt others by

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intensifying an explosive situation with incendiary language and to not hurt others by unintentionally using comments that could be experienced as disregarding, demeaning, offending, threatening, or rejecting?

As psychiatrists, we are expected to be self-aware, to cultivate our abilities to listen and respond empathically, and to understand the full range of human experience and emotion. As healers, we do not rub salt in the wounds of those whose views conflict with our own. Yet, rancorous recriminations were straining the seams of our organization, a microcosm of the hostilities in the outside world. Months of horrifying events in the Middle East were affecting our psychophysiological states, ramping up our perceptions of the world outside and of the environment inside the APA as unsafe.

We know that feeling unsafe activates the sympathetic nervous system and heightens defensive reactions. In this state of threat, we are primed for action (fight or flight), while our social engagement systems become less effective[4]. Consequently, we become less able to respond to people and situations with empathy, compassion and understanding. Our capacities for cooperation, flexibility, and closeness with others become compromised. Defensive reactions displace social engagement. Concurrently, a greater negative valence pervades our perceptions, interpretations, assessments, and responses. As imperfect humans, regulating our own reactions and striving to be impartial can be challenging, whether we identify with the suffering of Israelis, Gazans, or both.

Self-care includes taking time to notice our own states of mind and taking steps to restore ourselves to a more balanced state wherein we can feel calmer, think more clearly, listen with compassion and understanding, and be at our best in relating to others. For example, we could practice simple mind-body techniques that rapidly balance the autonomic stress response systems and improve stress resilience. Despite our busy schedules, we need to embed self-care in our daily routines[5].

Preserving a balanced, flexible psychophysiological state helped maintain a safe holding environment for our colleagues and ourselves. Eventually, as the writers of WG-1 met online in our virtual cubicles, we came to a deeper understanding of one another's ideas and the meanings of the words we were choosing. We came to a consensus.

The final proposed APA statement expresses the compassion and alarm our community feels for all who are suffering in the current war, especially the children whose lives are being lost or permanently scarred. We call for the immediate cessation of hostilities and release of hostages, which is essential to provide safety and relief, especially for the displaced persons. As mental health professionals, we recognize that mass national trauma in current and post-conflict societies causes widespread needs for humanitarian and therapeutic interventions[6,7]. The growing challenges to mental healthcare systems during and after mass disasters include the increased prevalence of psychiatric illness, paucity of mental health providers, medication shortages, insufficient available trauma-focused interventions, stigma, inequities or discrimination, and complex service barriers for displaced persons[6,7]. These obstacles, which already existed, are magnified by war.

Healthcare workers in war-torn environments also have traumatic experiences that increase their risk for developing anxiety, posttraumatic stress disorder, and depression[8]. Our APA statement urges mental health professionals worldwide to do all that they can to bring an end to this war and to help care for those who are affected by the war, including caregivers at risk for trauma.

The GMHPC continues to work to ease the suffering of those caught in the Israel-Gaza conflict. We also provide support, advice, and fellowship to other members and committees of the APA. In addition, this statement calls on psychiatrists to guide people to channel their energies and passions toward constructive negotiations, problem solving, and rebuilding of the lives, cultures, societies, and relationships that are being lost or damaged.

Whatever happens in the coming days and years, the Global Mental Health and Psychiatry Caucus intends to remain steadfast in its responsibilities for global mental health education, advocacy, and treatment, as well as for actively supporting our colleagues in the American Psychiatric Association.

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Developing Resiliency through Lifestyle Interventions

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Developing interventions that bolster resiliency is a much-needed global priority with the continuing onslaught of the devastating effects of chronic mental conditions. Resiliency is defined as the ability to recover from negative circumstances and has received much-renewed attention since the recent upsurge of global violence, trauma, and isolation. The outcomes may be subclinical, requiring a focus on well-being, or may progress into a diagnosable psychiatric disorder. Regardless of the severity of the symptoms, the impact on the individual and community is substantial.

Access to resources for well-being, psychiatric medications, and psychotherapy has been a long-standing issue, regardless of a person's socioeconomic status or wealth of the country. Compelling data points to the efficacy of incorporating lifestyle interventions for overall health and to the bidirectionality between physical and mental health. In fact, lifestyle interventions have been adopted by many medical societies to be used as first-line and/or adjunct for chronic medical conditions such as diabetes, hypertension, heart disease, and cancer[1]. As this emerging field is expanding, the Lifestyle Medicine Global Alliance has affiliated organizations in every continent whose members are trained and board-certified in evidence-based lifestyle interventions.

Expanding the discipline to include mental health has been taken on by numerous groups. In 2023, the Australasian Society of Lifestyle Medicine, in partnership with the World Federation of Societies for Biological Psychiatry, published guidelines for lifestyle interventions for major depressive disorders that expand formulations to include the biopsychosocial-*lifestyle* model[2,3]. Adding lifestyle interventions provides accessible, inexpensive, evidence-based much needed tools. Indeed, despite growing medications and therapeutics, the negative impact of depression continues to grow, as reflected by the increase in disability-adjusted life-years (DALYs), years lived with disability (YLDs), and years of life lost (YLLs)[4].

In August 2023, the American Psychiatric Association (APA) launched the Lifestyle Psychiatry Caucus, and President-elect of the APA at that time, Dr. Viswanathan, announced his presidential theme for the 2025 APA Annual Meeting as *Lifestyle Interventions for Physical and Mental Health*. Two books on Lifestyle Psychiatry have been published, which lays the groundwork for the science and importance of lifestyle interventions in mental health conditions. In 2019, APA Publishing released Noordsy's *Lifestyle Psychiatry*. In December 2023, Merlo and Fagundes published *Lifestyle Psychiatry: Through the Lens of Behavioral Medicine,* also offers a behavioral medicine lens that serves as a guide for primary care and psychiatric clinicians.

Lifestyle psychiatry divides the evidence into 6 pillars including physical activity, nutrition, restorative sleep, decreased stress, improved connection, and harm reduction of substances, which will be described briefly next.

Physical Activity

Exercise has been shown to improve overall fitness, improve mental health[5], and improve sleep quality in multiple studies[2]. Exercise does not need to be elaborate, as individuals with strength training, cardiovascular, flexibility, balance, and endurance have been shown to have fewer mental health symptoms and improved resilience[5].

Nutrition

Communities living in food deserts where they experience food insecurity and lack essential vitamins, minerals, proteins, and fiber in their diets can significantly benefit from nutrition education. Yet, communal kitchens, where meals are prepared and eaten together, have improved resiliency and social connections[6]. Additionally, decreasing consumption of ultra-processed foods and adequate intake of fiber have been shown to improve depression and anxiety symptoms and enhance brain and gut health[7].

Restorative Sleep

Underappreciated are the consequences of inadequate sleep's impact on mental health and resilience. Sleep disorders, another

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modifiable lifestyle factor, are common in individuals who experience depression, trauma, and other mental health-related symptoms. Sleep quality improves with increased social connections, exercise, and mindfulness practice.

Decrease Stress

Stress is inevitable, and acute stress may sharpen and focus concentration, while chronic stress maintains heightened cortisol levels, disrupts sleep, promotes neuroinflammation, and disrupts the gut microbiota[8]. Mindfulness, particularly mindfulness-based cognitive therapy, and other metacognitive practices, decreases the effects of chronic cortisol by working in a top-down approach by increasing the function of the parietal lobe, posterior and anterior cingulate cortex, and the prefrontal cortex[9]. Mindfulness practice helps improve sleep quality and resilience.

Connectedness

A significant consequence of trauma is social isolation, where individuals may experience loneliness and aloneness. This condition is associated with heightened levels of stress, increased distrust in local civic institutions, increased use of substances, and worsening sleep[8]. Societies that promote members to develop compassion for self and others are healthier. They experience less loneliness, suffer fewer consequences from mental health, and are more resilient[10].

Harm Reduction of Substance

Substance use may have self-perceived benefits of escaping or improving social interactions. Yet, long-term use of substances (i.e., alcohol, opioids, methamphetamine, cannabis, etc.) do not improve resilience, worsen mood, increase isolation, and decrease sleep.

A Call to Action

By training communities on the impact of lifestyle on mental and physical health, lifestyle psychiatry can be part of building resiliency within our communities. Lifestyle psychiatry focuses on empowering the individual to partner in their own health elevating a person's agency. This is especially important in helping individuals and communities who have experienced trauma. Moving from focusing on the trauma or negative circumstance to a positive lens is part of the task of building the resiliency of a community and individual.

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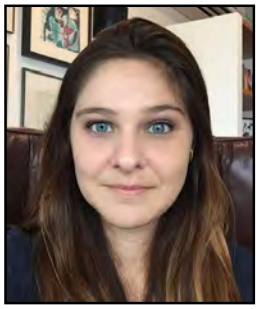
A Young Psychiatrist's Journey in a South Brazil Extreme Climate Event



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There are many pathways linking climate change and the disruption of mental health. This short article aims at describing the experience of a young psychiatrist attending Roca Sales, a city with 11,000 inhabitants in southern Brazil that was devastated by a cyclone and flood in September 2023, a result of the extratropical meteorological phenomenon El Niño aggravated by the warming of the oceans.

Clara works in a nearby town and was part of a group of citizens, among the many who voluntarily went to Roca Sales to offer help. The city had no history of cyclones or serious floods, they were unprepared. The group entered town only four days later when the water had receded. They found a dantesque scenario. Not only the poor areas near the river were destroyed: the city in its totality was a mixture of mud, upside-down vehicles, parts of houses and furniture, and fallen trees. The local hospital was totally destroyed. Volunteers helped the staff and population clean.

A group of psychiatrists who live in the region organized a WhatsApp list to manage the first urgent situations. Initially, they asked their acquaintances to send food, clothes and hygiene material. Then came the phase of identifying medical needs and asking for medication as they started to be called for emergency psychiatric cases. As the local health system had difficulties to reorganize, volunteers including physicians, psychologists, and nurses helped.

The first psychiatric cases were seen in a gymnasium where people were initially located. Mostly acutely agitated children and adults and some suicidal threats, a majority of them had previously diagnosed mental health problems. The symptoms were due to acute stress and/or lack of their usual medication. Many saw all their belongings disappear and remained all night on the roof of their houses. One woman with suicidality saw her husband disappear downstream.

Clara returned day after day. She reports that the pain she felt was compensated by the sense of helping and especially the solidarity that evolved among so many. As a plus, during the reorganization of the health system, she was hired to work in town. There was no psychiatrist there previously.

Clara offers a summary of two cases she is following as an example of how the psychiatrist can help: a middle-aged woman began treatment after the loss of her daughter and two granddaughters in the flood. The daughter's body has not yet been identified, which amplifies her pain and sensation of impotence facing death. She oscillates between moments of anger and sadness. She is being monitored by the local mental health and social assistance team. She resists taking medications but recognizes the importance of the psychotherapeutic support she is receiving. Another case is a 7-year-old boy whose parents are divorced. He lives with his mother, and his father lost his house in the flood and is still living in a shelter. The boy developed severe symptoms of anxiety. Every morning, he asks his mother to look at the weather forecast on her cell phone. When it rains, he feels very nervous, refuses to eat and feels nauseous. He has also exhibited childish behavior, starting to use a pacifier again. The boy is already undergoing psychological treatment and began psychiatric treatment last month.

We want to highlight, through this report, the urgent need to structure medium and long-term mental health services to

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address conditions like Prolonged Grief Disorder and PTSD, especially among vulnerable populations like children, adolescents, old adults and those with poor socioeconomic conditions. We aim to emphasize the need for collaboration between health and mental health professionals in urban restructuring post-disaster, with a focus on supporting frontline workers and early identification of professional burnout.

Roca Sales is reorganizing and is now included in the national system of alarm for severe climate events. We intend to help the region organize a quick health system response to climate disasters, as it is known that these events will happen more frequently as mitigation of climate change effects does not get an international consensual resolution.

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Chinese and World Perspectives of Disaster and Trauma

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Literature on trauma, resilience, healing and mental health all over the world in the last ten years include global perspectives, limited studies on traumas including war, earthquakes, and interpersonal conflict. First, regarding war, researchers have explored the effect of resilience on healing. Hobfoll SE, et al (2011)[1] reported that face-to-face interviews were conducted with a random sample of 1196 Palestinian adult residents of the West Bank, Gaza, and East Jerusalem across three occasions, six months apart (September 2007-November 2008). Latent growth mixture modeling identified posttraumatic stress disorder (PTSD), and depression symptom trajectories. Loss of psychosocial and material resources was associated with the level of distress experienced by participants at each time period, suggesting that resource-based interventions that target personal, social, and financial resources could benefit people exposed to chronic trauma. Galatzer-Levy IR et al (2013)[2] reported that adult survivors of potentially traumatic events consecutively admitted to Hadassah Hospital's emergency department (ED) from Jerusalem and vicinity were assessed ten days and one-, five-, nine- and fifteen months after ED admission. Participants with data at ten days and at least two additional assessments (n=957) were included; 125 received cognitive behavioral therapy (CBT) between one and nine months. The study concluded that the early course of PTSD symptoms is characterized by distinct and diverging response patterns that are centrally relevant to understanding the disorder and preventing its occurrence. Studies of the pathogenesis of PTSD may benefit from using clustered symptom trajectories as their dependent variables. Andersen SB, et al (2014)[3] assessed 743 soldiers deployed to Afghanistan in 2009 for PTSD symptoms using the PTSD Checklist (PCL) at 6 occasions from pre-deployment to 2.5 years post-deployment (study sample=561). Pre-deployment vulnerabilities and deployment and post-deployment stressors were also assessed. The results confirmed earlier findings of stress response heterogeneity following military deployment and highlight the impact of pre-deployment, peri-deployment, and post-deployment risk factors in predicting PTSD symptomatology and late-onset PTSD symptoms. Polusny MA, et al. (2017)[4] examined the prospective course of PTSD symptoms in a cohort of National Guard soldiers (N=522) deployed to combat operations in Iraq, and concluded that identifying pre-deployment vulnerability and post-deployment contextual factors provides insight for future efforts to bolster resilience, prevent, and treat posttraumatic symptoms. Kang H, et al. (2023)[5] analyzed the data from the 2019-2020 National Health and Resilience in Veterans Study (NHRVS), which surveyed a nationally representative sample of 3,847 trauma-exposed U.S. veterans. The results suggest that prevention and treatment efforts to mitigate severe PTSD symptoms, and help promote intrinsic religiosity, and more deliberate and organized rumination about traumatic experiences may help foster posttraumatic growth in veterans.

Second, regarding anti-human disasters, Pietrzak RH, et al. (2014)[6] reported that a total of 10835 WTC responders, including 4035 professional police responders and 6800 non-traditional responders (e.g. construction workers) who participated in the World Trade Center Health Program (WTC-HP), were evaluated an average of 3, 6 and 8 years after the WTC attacks. The results concluded that trajectories of PTSD symptoms in WTC responders are heterogeneous and associated uniquely with pre-, peri- and post-trauma risk and protective factors. Police responders were more likely than non-traditional responders to exhibit a resistant/resilient trajectory. These results underscore the importance of prevention, screening and treatment efforts that target high-risk disaster responders, particularly those with prior psychiatric history, high levels of trauma exposure and work-related medical morbidities. Orcutt HK, Bonanno GA, et al. (2014)[7] examined the impact of a campus mass shooting on trajectories of pre-shooting posttraumatic stress (PTS) in the 31 months following the shooting using latent growth mixture modeling in a sample with known levels of PTS symptoms, and found that pre-shooting functioning and emotion regulation distinguish between those who experience prolonged distress following mass violence and those who gradually recover. Ravn SL, et al. (2019)[8] studied to identify trajectories of PTSD symptoms following whiplash and test predictors and functional outcomes of such trajectories in a prospective cohort design. The results showed that three trajectories were identified, with the chronic trajectory suggesting that a significant subset of people does not recover from PTSD symptoms. This class also reported more pain-related disability. Pain and depression predicted membership, but did, however, not succeed in differentiating between the two high-starting trajectories, suggesting that targeting PTSD symptoms may be important to ensure recovery.

Third, regarding natural disasters, Zhu, et al. (2012)[9] reported that after six months of the Wenchuan earthquake, 2250 students (mean age=14.63) in Dujiangyan District were administered with

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the Adolescent Self-Rating le Event Checklist, Depression Self-rating Scale for Children and Resilience Scale, as well as demographic factors and earthquake exposure factors. The results underline the action mechanisms of resilience in preserving adolescents from depression. And the post-earthquake negative events could lead to depression and resilience displays an important role in adolescents' mental health. Okuyama J et al. (2018)[10] investigated a total of 760 high school students in Natori City, which was devastated by the Great East Japan Earthquake in 2011, and conducted longitudinal study with 254 students who had entered the school in 2012. This initial study profiling the characteristics of resilience among adolescents suggests that resilience is a highly changeable component of mental health among people who have faced adversity. Resilience can be a useful indicator of recovery from adversity and a target of interventions for improving mental health conditions. Schwind JS, et al. (2019)[11] reported that two strong earthquakes, as well as continuous, high magnitude aftershocks, struck Nepal in 2015. Phulpingdanda village was greatly impacted due to its lack of infrastructure and environmental remoteness. Adults from sampled households were surveyed one-year later to examine the association between earthquake exposures and indicators of depression, PTSD, and resilience. The results showed 33% of surveyed residents screened positive for depression, 9% screened positive for severe PTSD, and 46% displayed moderate to high resilience. This research adds to the knowledge of the relationship between traumatic exposures and indicators of psychological distress and resilience following a disaster. Xi Y, et al. (2020)[12] investigated the mechanism of PTSD after the 2017 7.0 Richter scale Jiuzhaigou earthquake in China. Three months after the earthquake, 607 participants from the heavily damaged areas were recruited. The result showed that PTSD, anxiety symptoms, and depressive symptoms prevalence were 52.7%, 53.8% and 69.6%, respectively. Resilience and social support had direct effects on PTSD, as well as indirect effects on PTSD through anxiety and depression. It explained the paths among the measured variables, which explained the risk and protective factors related to PTSD. Fuchs R, et al. (2021)[13] studied in local high schools throughout southeastern Louisiana 1000 adolescents who were exposed to Hurricane Katrina in 2005 and the Deepwater Horizon Oil Spill in 2010. The results found that disaster exposure was positively associated with trauma-like symptoms and substance use and psychological resilience were negatively related to these outcomes. These findings demonstrate childhood disaster exposure has the potential to cause chronic psychological distress and predispose individuals to substance use later in life. Obuobi-Donkor G, et al. (2022)[14] studied resilience after natural disasters using an online survey after a year of the 2020 severe floods in Fort McMurray. The prevalence of low resilience was 37.4%, showing a low resilience rate among respondents following the flooding. Factors contributing to low resilience include age, history of depression or anxiety, and place of residence after the flood. After the flood, receiving support from the government was shown to be a protective factor.

Summarizing the literature of the last ten years, trauma, resilience, and healing are highly associated. Therefore, intervention should be carried in different paths for different wars, anti-human and natural disasters in the world.

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Domestic and Family Violence – An Overview from Switzerland

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Domestic violence is a human rights violation. Switzerland is internationally known for its low crime rate, but when it comes to domestic violence, there is a different situation. In 2021 some 42% of women and 24% of men in Switzerland experienced domestic violence at least once. Women between the ages of 26 and 45 are the most affected. There are significant differences in terms of gender (75% are women and girls, 25% are men and boys), age groups and income classes, but almost none related to educational level[1]. In Switzerland an average of 55 crimes relating to domestic violence was registered per day in 2022. A person dies every 2.5 weeks on average due to attacks of this kind. This number increases slowly but constantly. In 2018 the daily average of domestic crimes was 52 crimes[2].

The family system represents the most proximal social environment for children. Frequent and/or high levels of conflict within the family, including arguing, competition, and criticism between family members, is associated with childhood depression, global distress, suicide and anxiety[3,4]. Family conflict is also a risk factor for more severe forms of dysfunction, such as children's victimisation by violence or family violence[5].

Despite its reputation for being one of the safest countries in the world, Switzerland still has a higher rate of conflicts in the domestic sphere compared to the European average[6].

It is important to note that such adverse childhood experiences ACEs can also occur in other settings, adding up to a high rate of 69% of a sample of young people aged 14 to 19 residing in Switzerland who have experienced at least one ACE. Since there is a well-established connection between ACEs and mental health, it is noteworthy that only 35-40% consulted a mental health professional more than twice in a period of 12 months, which is much lower than in other countries[7].

It is an important duty to eradicate those tendencies and improve prevention of domestic and family violence. In 2021 the Swiss government formally adopted a report that set out the country's agenda for preventing the escalation of domestic violence. The government wants to achieve this by means of awareness-raising campaigns, the provision of counselling and protection facilities and better prosecution[8].

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Trauma Resilience, and Artificial Intelligence – New Solutions to Old Problems?

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Trauma resilience refers to an individual's ability to cope with and recover from traumatic experiences. It involves developing a set of skills and strategies to help manage the emotional and physical responses to trauma. Building resilience can help individuals better cope with stress, anxiety, and depression, and can also improve overall mental health and well-being. Some strategies for building trauma resilience include practicing self-care, building a support network, seeking professional help when needed, and practicing mindfulness and relaxation techniques. Recently, self-compassion was indicated as significant interpersonal competence, even helping to reduce post-traumatic-stress symptoms[1].

Trauma resilience mobile applications are designed to support people who have experienced trauma and help them build resilience[2]. These apps can provide a range of resources and tools, including guided meditations, breathing exercises, cognitive behavioral therapy techniques, and stress management strategies. Some trauma resilience apps also offer community support features, such as forums and peer-to-peer messaging, allowing users to connect with others who have experienced similar trauma. These apps can be a helpful supplement to traditional therapy and can provide users with convenient access to support and resources wherever they go.

As artificial intelligence (AI) has the potential to greatly impact the field of trauma resilience, there is a new era to come. AI-powered virtual assistants and chatbots can be programmed to provide personalized support and resources to individuals who have experienced trauma[3]. These tools can offer a sense of safety, anonymity, and accessibility for individuals who may not feel comfortable seeking help in traditional settings. Additionally, AI algorithms can be used to analyze large amounts of data to identify patterns and risk factors associated with trauma. This information can be used to develop targeted prevention and intervention strategies.

However, it is important to note that the use of AI in trauma resilience also raises ethical concerns. For example, there may be concerns around data privacy and the potential for bias in the algorithms used, prioritizing the interests of doctors and patients[4]. As such, it is important for developers and practitioners to approach the use of AI in trauma resilience with caution and with a commitment to ethical and responsible use.

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MEDICINE, MENTAL HEALTH, AND THE HUMANITIES

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Poetry – A Novel and Innovative Method in Psychiatry and Mental Health

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Background:

Poetry has emerged as a novel and innovative medium in Psychiatry and Mental Health. Poetry can move the Soul, The Psyche of our Human Existence. The Butterfly represents the Transformation of the Human Soul, The Psyche. Historically, Poetry has been a beautiful medium for the Spiritual Maturation of the Human Psyche since ancient times. There is sparse literature on Poetry, Psychiatry and Mental Health.

Poetry and Training in Psychiatry:

Narrative medicine, story telling and patient history are very much at the heart of medicine. Creative mediums such as Poetry and Storytelling such as Schwartz Rounds and Balint Groups work have been used in Irish Psychiatry training programs[1]. A previous perspective paper highlights a particular interest in the Poetry inherent to an individual's story and appreciation of the artistic underpinnings of medicine may also contribute to the choice of Psychiatry as a career[2].

Poetry as an Empathy Enhancing Tool:

The use of Poetry as a Narrative Medicine Intervention has been found to increase empathy and there is limited evidence that it can reduce professional burnout among health care workers[3]. The Arts provides a unique opportunity to engage and reflect upon various affective dimensions which can help enhance empathy skills and emotional resonance within practitioners towards those receiving mental health care[4].

Poetry and Psychotherapy:

Poetry can have relevant applications in Child and Adolescent Psychiatry especially in the domain of Psychotherapy. Creative and Playful therapies with Bibliotherapy and Expressive writings have been found to be effective for certain types of disorders. Further, reading and writing are two of the main pillars of our educational system which can be utilized within a therapeutic setting[5]. Art therapy in the form of painting, Music and drama have been explored in rehabilitation programs. However, the use of poetry is less familiar and sparsely discussed in the literature. The relationship between the processes of psychotherapy and the writing and reading of poetry as illustrated by the patient's writings has found a role for Poetry in Psychotherapy[6].

Poetry and Psychoanalysis:

Certain Literature compares Poetry with Psychoanalysis. It postulates that Poetry is possible because of the nature of verbal language, especially its potential to evoke the sensations of lived experience. The fundamental potentials are the remnants of the personal relational context in which the language is learned and this view of language infuses psychoanalytic writings on Poetry[7]. Literature highlights the listening of the Analyst and the writing process of the Poet, how each listens to what is unsaid in the music of language. It has been found that the rhythm, meter, and the sounds of words constitute this music. The Sound and

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Poetry, Psychiatry and Mental Health in Psychiatric and Medical Education: A Collaborative Innovative Symposium by "The Poets of Psychiatry Group" at the World Psychiatric Association Regional Congress, WPARC 2023, Kolkata, India.

the image are the very means by which language bypasses logic and touches upon us. A Poem that can impact us and stir us inside can also help provide new insights to understand and reflect how words can affect us in psychoanalysis[8].

Neuroscience of Poetry:

Poetry is a creative multifaceted process rooted in neuroscience. There are divergent connectivity patterns centered upon the medial prefrontal cortex (for technical facility) and the dorsolateral prefrontal cortext/intraparietal sulcus (for innovation) in the human brain which suggest a mechanism by which experts produce higher quality poetry. The neuro-cognitive model is characterized by dynamic interactions between medial prefrontal areas regulating motivation, dorsolateral prefrontal, and parietal areas regulating cognitive control and the association of these regions with language, sensorimotor, limbic, and subcortical areas distributed throughout the brain has been found to be linked to the creative process in Poetry[9].

Poetry from Patient's Recovery Perspective:

Poetry as a recovery tool with its periodic reflection along with the support of family and peers and other recovery oriented realizations can help make the recuperation from mental illness less debilitating[10].

Poetry as a Teaching Learning Method in Medical Education:

The author has conducted a research project on "Effect of narrative storytelling and poetry on psychiatric disorders as teaching learning method in undergraduate medical students and post graduate residents for Psychiatry" as part of the Advance Course in Medical Education conducted by Seth GS Medical College and KEM Hospital, National Medical Commission Nodal Centre for Faculty Development. It is aimed for further presentation and publication in relevant conferences and journals in the near future.

The Poets of Psychiatry Group:

The author has founded a group called "The Poets of Psychiatry". It is a collaborative group of Psychiatrists who write Poetry and currently comprises 71 members from India and abroad. The aim of the group is to collaborate for Poetry in Psychiatry and Mental Health Awareness via programs, symposia, workshops, research and publications. The Poets of Psychiatry collaborated with the Digital Psychiatry Subcommittee, Indian Psychiatric Society Western Zonal Branch and conducted a

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Symposium: Poetry in Psychiatry and Mental Health by "The Poets of Psychiatry Group" at the 74th Annual National Conference of Indian Psychiatric Society, ANCIPS 2023, Bhubaneswar, India.

program on "Digital Poetry and Psychiatry" on 20th October 2022 which had esteemed Psychiatrists share their journey as Poets as well as Innovative Poetry reading on Psychiatric Disorders and Mental Health. The Poets of Psychiatry Group collaboratively conducted a symposium on "Poetry in Psychiatry and Mental Health" at the Annual National Conference of Indian Psychiatric Society, ANCIPS2023 Bhubaneswar, India. As esteemed members of the Poets of Psychiatry Group, Dr Darpan Kaur, Dr Madhur Rathi, Dr Dhruv Parmar, Dr Gulbahar Sidhu, Dr Rajashree Ray, Dr Tushar Jagawat conducted the national symposium at ANCIPS2023 and Dr Darpan Kaur, Dr Aruna Yadiyal, Dr Deepali Gul and Dr Gulbahar Sidhu conducted the collaborative innovative symposium on "Poetry, Psychiatry and Mental Health in Psychiatric and Medical Education" at the World Psychiatric Association Regional Congress, WPARC 2023, Kolkata, India. Digital Psychiatry Subcommittee, Indian Psychiatric Society Western Zonal Branch in collaboration with The Poets of Psychiatry Group conducted an online program on "Digital Poetry and Mental Health Awareness" on 7th October 2023. The Poets of Psychiatry Group plans to further expand the collaborative network and publish an Anthology and a collaborative paper in 2024. It aims for meaningful collaborations, innovations and connectedness amongst the Poets of Psychiatry for enhancing community awareness on Psychiatric disorders and mental health problems via the creative medium of Poetry in Psychiatry and Mental Health.

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BOOK REVIEW

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"Two Kinds of People in a Time of War"

A Reading of Two Kinds of People by Vincenzo Di Nicola

by Jan Jorgensen, MAR, MDiv

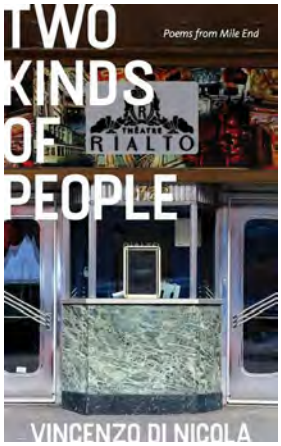
Jan Jorgensen
Photo: Ted Krasnicki

Jan Jorgensen, MAR, MDiv

Jan Jorgensen is a poet and a pastor at the United Church on Kahnawake Mohawk Territory across the river from Montreal. She was educated at Bard College and Yale Divinity School (MAR, 1986; MDiv, 1991). She founded and co-hosts a long-running literary soirée series in Montreal. Her forthcoming volume of poems and prayers is called *Birthing Godde* (Jorgensen, 2024).

Review of:

Two Kinds of People: Poems from Mile End
Vincenzo Di Nicola
With photography by Arsinée Donoyan.
Afterword by Stanzi Vaubel, PhD.
Singapore: Delere Press, July 15, 2023.
ISBN-10: 9811833508 ISBN-13: 978-9811833502
52 Pages
Format: Paperback
List Price: $15
(Nominated for The Pushcart Prize.)



This review, my second reading of Vincenzo Di Nicola's book, is entitled "Two Kinds of People in a Time of War," for this sorrow is much on my mind, and I am grateful for the way the poet "ironically undermines all the partisan calls for totalizing truth" (Di Nicola, Qossoqsi, & Jorgensen, "Borders, Belonging, and Betrayals," 2024) in his book and in our on-going poetic conversations (Di Nicola, Moffic, 2023; Jorgensen, 2024).

Released this year and nominated for the Pushcart Prize, *Two Kinds of People* holds the imagination enthralled as philosopher-psychiatrist Vincenzo Di Nicola leads us on a poetic journey outlined in *Milestones.* These are: "*Mile End Station / Point of Departure / Itinerary – Half-way marker – Terminus / Envoi* / no poem but the world." We begin at Mile End Station with a prescient epigram taken from *The Book of Disquiet* by Bernardo Soares. Next, Di Nicola skilfully employs yet another quote, this time from The Rolling Stones, laying down the tracks that tie together this ride through Montreal's Mile End neighbourhood. *Itinerary* provides groupings of the alleged two kinds of people whom we will encounter. And then unsurprisingly, perhaps, at the *Half-way marker* we find ourselves shifting in our seats.

As we move through the book, we will observe what Di Nicola calls "philosophy's three gestures," namely "dialogue, laughter (irony), and silence" (Personal correspondence, December 27, 2023). For instance, in "Mile End's Bagel Cosmology," we move from the near agelessness of the universe, through enchanting notions of perception, to two bagel shops in Montreal's Mile End. We overhear allusions to dialogues between the poet and scientists, the poet and a theologian, as well as with Wallace Stevens, and a city that takes its bagels very seriously. Throughout his poetic narrative, Di Nicola draws upon a vast artistic repertoire to engage in dialogues with friends, philosophers, literary writers, and musicians through the use of epigrams and poetry.

Indeed, the book itself is a marvelous dialogue with the photographer-artist, Arsinée Donoyan, whose images complement the poetry, providing landmarks for those who have never visited Montreal. This dialogical poetry is deeply engaging. At times there is spaciousness within poems. Di Nicola might utilize brief word sketches capturing moments in time and space. In the title poem, "Two Kinds of People," the word "or" repeats in a litany of dichotomies gleaned from history, literature, and ordinary life, casting doubt on the notion of two kinds of people. Near the end of the poem we see:

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There's no stark raving sane
or lucid lunatics
common sense can tell you
that much

Di Nicola plays with themes and words and sounds. We discover over and over the significance of foods. We sometimes encounter the dense almost architectural layering of words and images filled with irony, as in the book's prose-poem, "*La Millefoglie* – City Layer Cake." Comparing cities with a childhood favourite of layered pastry and cream or savoury filling, the poet tells us:

Cities are like that.

As much as you try to lift off the top layer, you
find that in biting into it,
you bite into the past: your experience is
layered.

With any of these poems we can pause and wonder about the ways we perceive our own surroundings, or our own encounters. We can examine our own notions of "two kinds of people," both the times when we half believe the axiom, and the times when we reflect upon the complexities of what it means to be human.

Once I wrote: "Playfully, the philosopher-poet engages Montreal's Mile End in a serious dialogue."

Now I see how Di Nicola's ironic use of "two kinds of people" is deadly serious. In these difficult times, this poetry engages us in conversations that remind us:

In a dialogue, there is only one single refraction of thought: this is produced by the partner in conversation, the mirror in which we want to see our thoughts reflected as beautifully as possible.
– Friedrich Nietzsche, *Human, All Too Human*.

I would invite you to contemplate the image on the page marked *Envoi.* The poet is transformed by gazing upon the face of his newborn daughter. In his last poem there are those who speak of reasons for silence; the poet writes:

you are the miracle your mother prayed for
yet words don't fail –
they stop short before beauty:
there is no face but your face
upon which to set my tired eyes;
and no poem but the world

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SAT. - WED. MAY 4-8, 2024	**American Psychiatric Association (APA)** **ANNUAL MEETING** MAY 4-8, 2024 • NEW YORK, NY
MON. - FRI. MAY 20-24, 2024	**International Association for Child & Adolescent Psychiatry and Allied Professionals (IACAPAP)** **26th WORLD CONGRESS OF IACAPAP** MAY 20-24, 2024 • RIO DE JANEIRO, BRAZIL
MON. - THU. JUN. 17-20, 2024	**Royal College of Psychiatrists (RCP)** **INTERNATIONAL CONGRESS 2024** JUN. 17-20, 2024 • EDINBURGH, SCOTLAND
THU. - SUN. NOV. 14-17, 2024	**World Psychiatric Association (WPA)** **CONGRESS OF PSYCHIATRY** NOV. 14-17, 2024 • MEXICO CITY, MEXICO
SAT. - SUN. OCT. 25-26, 2025	**International Conference on Psychology, Psychiatry, Neurological, Behavioral and Cognitive Sciences** **ICPPNBCS 2025** OCT. 25-26, 2025 • BARCELONA, SPAIN

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