



Welcome to the Society for Occupational Health Psychology Newsletter!

SOCIETY FOR OCCUPATIONAL HEALTH PSYCHOLOGY

Volume 19 (Spring, 2018)

Welcome from the Editor



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Dear SOHP Members and Friends,

Welcome to the Spring 2018 edition of the SOHP Newsletter. The past few months have been quite unpredictable; at least weather-wise here in the North East we have gone from extreme winter to a summer climate seemingly overnight! Where the heck did Spring go? Oh well, mother nature has a couple more weeks left to remind us that yes, it is still Spring.

With this newsletter, we are pleased to welcome the newly elected SOHP officers and committee chairs who will serve until December 2019. Some other exciting news is that after much planning and effort the Society now has a refreshing new website that was successfully launched under Past President Lisa Kath's direction. Remember to spread the word about OHP in your work endeavors and through social media, and please share <https://sohp-online.org> with your co-workers and friends.

This newsletter includes some very interesting topics. We begin with a column from Clemente Diaz, Associate Director College Now, Baruch College, City University of New York about mental health stigma that persists in the workplace. He shares information about available evidence-based training programs that teach participants how to identify, understand, and respond to signs of mental illnesses and substance use disorders.

Ellen Cobb, JD provides a book review for "Workplace Bullying and Mobbing in the United States." This multi-contributor book

on workplace bullying is grounded in American employee relations and was published at the start of this year.

This edition's OHP Researcher / Practitioner Stories includes a column from Marvin J. Dainoff, PhD, CPE who offers insightful reflections of his journey, encompassing over three decades, in OHP, I/O Psychology and Human Factors/Ergonomics.

Shana Palmieri, LCSW provides an article titled, Successful Management of Employees with PTSD in the Workplace. She provides information about Post-Traumatic Stress Disorder, what PTSD in the workplace looks like, and how employers can create opportunities for success for employees with PTSD.

Gil Brady, PhD offers a column titled, Let's fire the Cult of "Boom → PTSD" and improve veteran reintegration into the modern workplace. He shares insights into his research and provides some recommendations for business leaders seeking to better the odds of success for their veteran employees.

Last but not least, we include a report published from the 6th International Congress of the International Commission on Occupational Health - Work Organization and Psychosocial Factors (ICOH-WOPS), conference that took place on August 29 - September 1, 2017.

Many **thanks** to those who have contributed including the editorial team for their time and effort and a **special thank you** to Gary Giumetti for assisting with production of the newsletter. Heartfelt congratulations to our production editor Lauren Murphy on the birth of her new baby! In keeping it fun please enjoy the OHP Word Search Puzzle on the back page of the newsletter.

From now till then, continue along your journey in this wonderful field, be well and *please* keep us informed so that we may share your meaningful work experiences and insights with others.

If you have any comments or would like to write an article for a future issue, please e-mail me (tsidawiostojic@ccny.cuny.edu).

Tanya Sidawi-Ostojic

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Inside this issue:

ANNOUNCING THE NEW SOHP OFFICERS AND COMMITTEES	2
MENTAL HEALTH FIRST AID IN THE WORKPLACE	3-4
UPCOMING OHP CONFERENCES	4
BOOK ANNOUNCEMENT: WORKPLACE BULLYING AND MOBBING IN THE US	5
OHP, I/O, & HUMAN FACTORS: REFLECTIONS ON A LONG JOURNEY	5-6
REPORT FROM 6TH ANNUAL ICOH-WOPS CONFERENCE	7-8
IMPROVING VETERAN REINTEGRATION INTO THE MODERN WORKPLACE	9-11
SUCCESSFUL MANAGEMENT OF EMPLOYEES WITH PTSD IN THE WORKPLACE	12
OHP-THEMED WORD SEARCH	13

Announcing the New SOHP Officers and Committees for 2018-2019!

Dear SOHP Members,

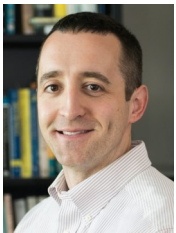
Thank you to everyone who voted in the Fall election. We are delighted to announce our new slate of officers for the January 2018 - December 2019 term:



Past-President
Lisa Kath, PhD
Professor
San Diego State University



Current President
Tammy Allen, PhD
Professor
University of South Florida



President-Elect
Christopher Cunningham, PhD
Professor
The University of Tennessee at Chattanooga



Member-at-Large
Larissa Barber, PhD
Associate Professor
Northern Illinois University



Member-at-Large
Gwen Fisher, PhD
Associate Professor
Colorado State University



Secretary-Treasurer
Joseph Mazzola, PhD
Associate Professor
Roosevelt University

These officers compose the SOHP Executive Committee, and they will work closely with the chairs of other standing and ad-hoc committees to support the research and practice of occupational health psychology.

We would like to thank each of the outstanding members who accepted nominations to run for office. The number of individuals willing to serve is indicative of the engaged and healthy organization we have.

We also thank the officers who are rotating off the Executive Committee for their leadership, service, and commitment to SOHP: Mo Wang, Carrie Bulger, and Mike Ford.

If you would like to get more involved in SOHP or have ideas for the Executive Committee to consider, don't hesitate to contact me.

Sincerely,

Tammy Allen, President, SOHP

Current SOHP standing committees:

Communications committee:

Chair: Tanya Sidawi-Ostojic



Education and Training Committee:

Co-chair: Ashley Nixon, Willamette University
Co-chair: Irvin Schonfeld, The City College of the City University of New York and CUNY Graduate Center



Graduate Student Issues Committee:

Nikola Fedorowicz, University of Houston



Membership Committee:

Chair: Yujie Zhan, Wilfred Laurier University



Current Ad-hoc Committees and Appointed Positions:

Awards Committee:

Co-chair: Vicki Magley, University of Connecticut
Co-chair: Naomi Swanson, NIOSH



Elections Committee:

President-elect

SOHP-online.org:

Currently seeking a volunteer. Please contact President@sohp-online.org if you are interested in this position.

Help Wanted:
Webmaster

Work Stress & Health Conference Workshop Committee:

- Chair: Michael Ford, University of Alabama



Mental Health First Aid in the Workplace

Clemente I. Diaz

Baruch College, City University of New York and the CUNY School of Professional Studies

Employee mental health and substance abuse issues negatively impact organizations on multiple levels. According to the National Council for Behavioral Health (2013), 35 million workdays are lost annually due to mental illness. Additionally, the cost of untreated mental illness in the United States is roughly \$105 billion annually, mostly due to loss of productivity. With 1 in 5 American adults having a mental illness and 1 in 10 having an addiction, one can be sure that every organization will be affected sooner or later (National Council for Behavioral Health, 2013).

Due to its negative impact on business many organizations have implemented programs for those experiencing mental health and/or substance abuse issues. More specifically, 93 percent of North American employers offer mental health/substance abuse benefits (Miller, 2016). Of these organizations, 88 percent offer Employee Assistance Programs (EAP), 40 percent offer wellness programs and 30 percent offer health risk assessments.

At the City University of New York (CUNY), where I work, mental health and substance abuse resources are in the form of a partnership with Deer Oaks, which provides employees with eight confidential short-term counseling visits, substance abuse services, and crisis intervention, among other benefits.

While EAPs are a great resource they are still not enough as mental health stigma persists in the workplace. Due to this stigma many employees are often hesitant to disclose to supervisors, colleagues or even the Human Resources department, problems they may be facing (Rauch, 2016). Workplace mental health stigma, along with poor organizational communication about available resources, is the primary reason EAPs are severely underutilized with roughly less than 5 percent of employees taking advantage of them (Dunning, 2014). Additionally, seldom do managers and non-managers alike know how to properly assess and/or assist a colleague experiencing a mental health or substance abuse crisis. Oftentimes managers and employees may feel it is not their place to provide assistance as they are not mental health or substance abuse professionals. It's no surprise that roughly 85 percent of employee's mental health problems go undiagnosed and/or untreated (Rauch, 2016).

In addition to providing EAPs, employers have to destigmatize mental health issues in the workplace as well as be able to assess their employee's mental health. That's where Mental Health First Aid (MHFA) comes in. MHFA is an evidence-based training program that teaches participants how to identify, understand, and respond to signs of mental illnesses and substance use disorders (National Council for Behavioral Health, 2013). Similar to the way Cardiopulmonary Resuscitation (CPR) assists in helping someone during medical, breathing or cardiac emergencies, MHFA helps individuals assist those experiencing a mental health or substance use-related crisis. In addition to learning about risk factors and warning signs of mental health and addiction issues, participants learn strategies on how to help someone in both crisis and non-crisis situations, as well as where to turn for help (National Council for Behavioral Health, 2013).

According to the National Council for Behavioral Health, who oversees MHFA training in the United States, after being trained in MHFA employees report increased confidence in their ability to recognize the signs of mental health and/or substance abuse issues, their willingness to reach out to someone who may be experiencing such issues, and increased confidence in connecting a distressed co-worker to appropriate resources (National Council for Behavioral Health, 2013).

MHFA's action plan focuses on the easy to remember acronym, ALGEE.

- Assess for risk of suicide or harm
- Listen non-judgmentally
- Give reassurance and Information
- Encourage appropriate professional help
- Encourage self-help and other support strategies

Having every member in an organization trained in MHFA demonstrates an organization's overall dedication to combating mental health and substance abuse issues, reducing the associated stigma, encouraging members to take advantage of available EAPs (and other resources), and ultimately creating a culture of acceptance. While having senior leadership buy-in and the formal implementation of MHFA training would be ideal, it's not necessary. Changes can potentially occur from the bottom up, albeit not at the same pace as if the organization as a whole was onboard. Below are some examples of the steps some of my colleagues and I have taken to promote MHFA at our workplace.

- Many of us have completed the 8 hour MHFA certification course through the NYC Department Mental Health and Hygiene.
- We continuously encourage our colleagues and staff to become certified in MHFA as part of their professional development.
- As co-chair of the Baruch College Advising Alliance, a grassroots inter-department resource group, I assist in organizing MHFA workshops and other mental health related workshops for staff.

Continues on page 4



Clemente Diaz
Associate Director
College Now, Baruch College,
City University of
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"...93 PERCENT OF NORTH AMERICAN EMPLOYERS OFFER MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS (MILLER, 2016)."

"WORKPLACE MENTAL HEALTH STIGMA, ALONG WITH POOR ORGANIZATIONAL COMMUNICATION ABOUT AVAILABLE RESOURCES, IS THE PRIMARY REASON EAP'S ARE SEVERELY UNDERUTILIZED WITH ROUGHLY LESS THAN 5 PERCENT OF EMPLOYEES TAKING ADVANTAGE OF THEM (DUNNING, 2014)."

Mental Health First Aid in the Workplace (continued)

- One of the other co-chairs of the Baruch College Advising Alliance has completed additional training and is now a certified MHFA Instructor. As a trainer he has facilitated trainings across CUNY.

As an adjunct faculty, I have my students participate in MHFA training for extra credit.

I hope this article will encourage you and others to take the first step in changing how mental health is viewed and dealt with in the workplace. To learn more about MHFA and find training locations near you visit www.mentalhealthfirstaid.org. MHFA trainings are generally offered at no cost to by local governmental agencies and non-profit organizations. In New York City the Department of Mental Health and Hygiene has been tasked with training all New Yorkers for free. For information on how to formally implement MHFA as part of your organization's wellness programs and/or employee training programs visit www.mentalhealthfirstaid.org/at-work/.

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Upcoming OHP-related Conferences

13th European Academy of Occupational Health Psychology Conference

- September 5-7, 2018 - Lisbon, Portugal
- Organized by: the European Academy of OHP, the Business Research Unit at University Institute of Lisbon (BRU-IUL)
- For more info, visit: <http://www.eaohp.org/conference.html>



Employability in the 21st Century - 2nd International Conference on Sustainable Employability

- September 12-13, 2018 - Leuven, Belgium
- Organized by: Securex, Ghent University, University of Liège, ICOH SC Aging and work
- For more info, visit: <http://www.icohweb.org/site/events.asp#event0> and <http://www.employability21.com/>



Work, Stress, and Health 2019

- November 6-9, 2019 - Philadelphia, PA
- Organized by: American Psychological Association, NIOSH, and SOHP
- For more info, visit: <http://www.apa.org/wsh/>



First Comprehensive Multi-contributor Book on Workplace Bullying and Mobbing in the United States Published

Ellen P Cobb, JD



Ellen Cobb, JD

Workplace Bullying and Mobbing in the United States, the first comprehensive, multi-contributor book on workplace bullying and mobbing grounded in American employee relations, was published at the start of this year. Editors Maureen Duffy, PhD and David Yamada, JD have assembled information in 25 chapters written by over two dozen contributors in a two-volume set. The material is presented in six parts: Understanding Workplace Bullying and Mobbing; Examining the Impact of Workplace Bullying and Mobbing; Prevention of Workplace Bullying and Mobbing; Utilizing Effective Interventions in Responding to Workplace Bullying and Mobbing; The Legal Landscape in the United States for Workplace Bullying and Mobbing; and Workplace Bullying and Mobbing within Specific Employment Sectors. These specific sectors address health care, K-12 settings, higher education, public service, and the corporate and non-profit sectors.

This timely and essential resource is extremely readable, geared towards a general audience as much as professional and legal one. It examines the damaging effects of workplace bullying on both individuals and organizations; identifies what constitutes effective prevention and intervention; surveys the legal landscape for addressing the problem, from both American and multinational employers perspectives; and provides practical recommendations for prevention and amelioration of these behaviors.

"THIS TIMELY AND ESSENTIAL RESOURCE IS EXTREMELY READABLE, GEARED TOWARDS A GENERAL AUDIENCE AS MUCH AS PROFESSIONAL AND LEGAL ONE."

Maureen Duffy and David C. Yamada, Editors

Workplace
Bullying AND
Mobbing
IN THE
United States



Editor David Yamada states: "Our primary purpose in developing this book set was to bring together important research and thinking about workplace bullying and mobbing from leading and emerging American researchers, theorists, and practitioners and to present that work in a comprehensive and systematic way." Workplace Bullying and Mobbing in the United States succeeds in its purpose and more, offering chapter after chapter of helpful and informative analysis. This two-volume book set is highly recommended for researchers, practitioners, and a general audience wanting to learn about this increasingly acknowledged workplace issue. More information may be found at <https://www.abc-clio.com/ABC-CLIOCorporate/product.aspx?pc=A5184C>.

By Ellen Pinkos Cobb, JD Author of Workplace Bullying and Harassment: New Developments in International Law (Routledge, 2017) ; Workplace Bullying and Mobbing in the United States-Chapter contributor: Comparing and Contrasting Workplace Bullying and Mobbing Laws in Other Countries with the American Legal Landscape.

OHP, I/O Psychology and Human Factors/Ergonomics: Some Reflections on a Long Journey

Marvin J. Dainoff, PhD, CPE

By nature, I like to make connections among different entities, to cross boundaries. This perhaps gives me a useful perspective to look at the interrelationship between I/O psychology (which presumably forms a good part of the core discipline of OHP) and human factors/ergonomics.

I received my PhD in 1969 from University of Rochester in visual perception and cognition (then called information processing approaches to perception.) I got a teaching position in the psychology department at Miami University (Ohio) where I remained for the next 35 years. Sometime in the mid-1970s, the department decided we should have an advanced undergraduate/graduate course in Human Factors, and I agreed to teach it. A few years later, the person teaching our sophomore I/O course (called Business Psychology at Miami) retired, and it seemed I was the natural person to step in. No one trained in I/O was in the department and the retiree was not going to be replaced. Thus do seemingly small administrative decisions lead to long term career impacts.

The reason this decision seemed natural is due to the remarkable career of Ernest J. McCormick, the late professor of Industrial Psychology at Purdue, and inventor of the Position Analysis Questionnaire (PAQ). McCormick wrote his first textbook of Human Factors in 1957. This was two years after I graduated high school! The next year he wrote a textbook for Industrial Psychology with Tiffin. This pattern of alternating books continued until 1990, when he passed away. The result was 8 editions of what became the I/O book (later editions were written with Ilgin) and 6 editions of the Human Factors book (later editions were written with Sanders).

This pattern was clearly evident to a junior professor in the mid 70s, leading to the perception that Human Factors and I/O Psychology were closely linked. Indeed, when I was approached about teaching the I/O course, I looked at the current edition of McCormick and Tiffin, and noted that almost a third of the content overlapped with the current edition of McCormick's Human Factors text. McCormick himself received major awards from both the Human Factors Society



Marvin J. Dainoff, PhD, CPE

OHP, I/O Psychology and Human Factors/Ergonomics: Some Reflections on a Long Journey (continued)

and APA.

At this point, the stereotype was that Human Factors dealt mostly with design of knobs, dials, and switches. Ergonomics, originally a term of European origin, was seen to focus on injury and health issues associated with manual work. (APA seemed to ignore both of these labels, using the term Engineering Psychology.) However, the arrival of computer technology into the workplace beginning in the late 70s started to change all of this. On both sides of the Atlantic, there came a realization that human factors and ergonomics were two aspects of the same discipline; the Human Factors Society became the Human Factors and Ergonomics Society (HFES). The dominant professional disciplines for HFES members were becoming either cognitive psychology or systems/industrial engineering. Perhaps sensing that HF and I/O were drifting apart, the late Hal Hendrick, with some like-minded colleagues, developed the concept of *macroergonomics*. It is not an accident that Hal was a student of Ernest McCormick. Macroergonomics represented a realization that, professionally, we needed to build bridges, not silos. Work systems required an integrated multidisciplinary approach.

Jump ahead 25 years. The junior professor pondering whether he can teach both human factors and I/O psychology just has been elected a member of the Board of Certification in Professional Ergonomics, and put in charge of updating the existing certification examination. Professional certification has its own body of procedures and standards; they include a requirement to carry out a systematic content analysis of the profession as a basis for examination development. Fortunately, Hal Hendrick was a fellow board member and had recently (Hendrick, 2000), produced exactly the kind of framework that was needed. We used it to restructure the examination content, and I present it here as a guide to collaboration.

Table 1

The Technology of Ergonomics (Hendrick, 2000)

Human Factors/Ergonomics is a unique discipline, which through scientific research, has developed its own technology: **Human Systems Interface Technology**, with the following components

Human-Machine Interface Technology (Equipment/hardware design)

Human-Environment Interface Technology (Physical work environment)

Human-Software Interface Technology (Cognitive ergonomics/usability)

Human-Job Interface Technology (Work design)

Human-Organization Interface Technology (Macroergonomics: joint optimization of the "micro" levels of technology below with respect to organizational design)

Glancing at any contemporary I/O textbook, I would argue that there are multiple points of overlap with this framework. This is particularly true for the OHP community. I would emphasize that macroergonomics is explicitly based on a sociotechnical system theory foundation. As such, it is concerned with the harmonization of technical, human, organizational, and environmental components of the work system. Other overlapping sub-disciplines of possible interest include cognitive systems engineering, human systems integration, and resilience engineering. These latter approaches, while rooted in systems engineering, share with macroergonomics the core value of integration of technical and human considerations, specifically merging engineering and behavioral science method and theory.

This leads me to my last point: the need for collaboration. To succeed while working within a sociotechnical framework, a multidisciplinary perspective is essential. There is simply too much information for one person to master. One needs the ability to be able to ask for help, to be able to work with professionals who did not share your same intellectual grounding. There are colleagues who have deep expertise in relative narrow topics; they are valuable resources but only if you can negotiate the basis for mutually beneficial collaboration. In my experience, this is not necessarily straightforward. It takes a lot of work, but to solve complex, real world problems, there is no real alternative.

Reference

H. W. Hendrick, (2000) *The Technology of Ergonomics*. *Theoretical Issues in Ergonomics Science*, 1, 22-33.

"ERGONOMICS, ORIGINALLY A TERM OF EUROPEAN ORIGIN, WAS SEEN TO FOCUS ON INJURY AND HEALTH ISSUES ASSOCIATED WITH MANUAL WORK. (APA SEEMED TO IGNORE BOTH OF THESE LABELS, USING THE TERM ENGINEERING PSYCHOLOGY.) HOWEVER, THE ARRIVAL OF COMPUTER TECHNOLOGY INTO THE WORKPLACE BEGINNING IN THE LATE 70S STARTED TO CHANGE ALL OF THIS."

Report from 6th International Congress of the International Commission on Occupational Health - Work Organization and Psychosocial Factors (ICOH-WOPS), August 29-September 1, 2017

During the 6th International ICOH Conference on Work Organization and Psychosocial Factors (WOPS), a Panel Discussion on Workers' Mental and Physical Health Priorities was held, with the participation of experts from Brazil, Colombia, Spain, United States and the Pan-American Health Organization, and the exchange and contributions of all attendees to the conference.

Based on several context considerations about the world of work, the dialogue held between the experts and the audience, and the conclusions from the panel, the organizers of the conference declare that:

1. As a result of globalization, the effects of informatics technology, massive communications and many of this manmade tools, life in the XXI century has created a paramount variety of stressors within the world of work and far beyond, making geographic and time boundaries in existent, as well as individual's private life and working life boundaries seem to be erased.
2. There is an intertwining close relationship of mental health and work taking into account the definition made by WHO in 2012, and the WHO comprehensive Mental Health Action Plan 2013-2020, launched and adopted by the 66th World Health Assembly (WHO, 2017), that strongly reaches out to strengthen effective leadership and governance for mental health; and to implement strategies for promotion and prevention in mental health.
3. The evidence showing that life stressors, including those coming from the inequities of work (work content) and employment conditions (labor context) (WHO, 2016), can have disastrous consequences on workers' health and wellbeing. One of them is the permanent work and family communications taking over personal, family, and leisure time, creating a misbalance that affects workers' health in all dimensions: physical, mental, psychological, family, spiritual, and social health.
4. Detection, diagnosis, and visibility of mental health disorders, including major depressive disorders, anxiety and bipolar disorders, acute stress and post-traumatic stress disorders, are linked to working and employment conditions. These links are reflected in the declaration of the global epidemics of "Workplace Stress, a collective challenge" done by ILO in 2016 (ILO, 2016), and WHO's global campaign "Depression: let's talk" launched during the World Health Day in 2017 (WHO, 2017).
5. The fact that the burden of these problems detected at the work place is often placed on the worker, biasing solutions to frame actions under the "healthy self-management" approach. Not addressing the basic causes of the problems present in work environment, the managerial styles, or the ways organizations work neglect the measures to prevent and control the causes of mental, emotional or mood disorders.
6. The need to prioritize preventive actions to improve workers' health and wellbeing with a holistic and gender approach can be done by:
 - a. Encouraging employers to understand that workers are their most valuable asset, and to have workers' health as a priority in their policy, mission, vision, values, and goals.
 - b. Creating awareness about mental health by listening and holding dialogues with managers and workers, as well as translating knowledge and disseminating information to create awareness in society as a whole.
 - c. Using screening and sentinel events to foresee early signs of poor mental health at the workplace before they become a real problem.
 - d. Focusing on prevention to address problems that affect mostly young working populations and avoid extreme decisions such as suicide.
 - e. Using holistic and long-term approaches for health care and occupational health services that are capable of providing multidisciplinary, comprehensive, and sustainable solutions for workers' mental and physical health problems.
 - f. Implementing workplace interventions using different sectorial points of view (health, labor, education, industry, etc.), with a multilevel perspective that involves management, workers, families, society, and health and labor institutions.
 - g. Advancing research to understand how modern societies induce to stressful living and working conditions affecting all dimensions of workers' health, and seeking ways to build resilience.
 - h. Creating and enforcing a culture for youth health at basic education levels, preferably before young adults enter into the labor market.
 - i. Promoting public policies based on evidence to enhance mental health promotion for the entire workforce.
7. Encourage the design and implementation of workers' mental health promotion activities or programs¹ as effective



Report from 6th International Congress of the International Commission on Occupational Health - Work Organization and Psychosocial Factors (ICOH-WOPS), August 29-September 1, 2017 (continued)

solutions to improve working and employment conditions, including:

- a. Using highly effective interactive and participatory approaches involving workers and managers.
- b. Changing managerial styles towards creating healthy workplaces and eliminating exploitation, discrimination, inequalities, and other forms of unfair work.
- c. Using tools and practices of occupational health psychology and positive psychology taking account of gender, age, multiculturalism, ethnicity, generational differences, within others, which coexist in working populations.

¹ Mental health promotion involves actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles. These include a range of actions to increase the chances of more people experiencing better mental health (WHO, 2016).

- d. Enhancing the implementation of a culture of healthy workplaces that can improve worker's performance, productivity, and wellbeing.
 - e. Using multilevel approaches to promote healthy lifestyles at individual level; promote protective factors at the enterprise level; encourage flexibility and adaptation to the changing world of work; and, learn from experiences and good practices to replicate them.
 - f. Encouraging permanent dialogue between government and society involving all stakeholders (unions, employers, academia, researchers, OHS professional associations, health systems, OHS services, etc.) to understand the needs for changing public labor and health policies that affect workers' health.
 - g. Keeping in mind that macroeconomic models impose certain rules and restrictions to job performance and productivity, particularly for small and medium size enterprises, as well as informal and self-employed workers.
 - h. Understanding and addressing the complexity of workers' health problems caused in and out of the workplace, with a holistic approach that can provide multidisciplinary services and support within national health systems.
 - i. Ensuring to collect, register and analyze data, and document the experiences that provide the evidence of successful and non-successful solutions.
8. Promoting and putting in place alternative solutions that can contribute to build healthy, productive, happy, and resilient workplaces and societies, such as:
- a. Using the evidence of experiences and practical solutions.
 - b. Promoting quantitative and qualitative research oriented to interventions/actions.
 - c. Increasing democratic practices for knowledge translation and information dissemination.
 - d. Encouraging the participation of all stakeholders and the use of modern communications through networks and communities of practice focusing on mental health and work.
 - e. Disseminating information through information technology and social media.
 - f. Integrating public health policies and health authorities in the practice of workers' health programs at the workplace by addressing individual health as a whole.
 - g. Strengthening the practice of organizational and positive psychology for addressing mental health and work, as well as work and life styles.
 - h. Maintaining a spirit of constructive observation and objective criticism to analyze workers' health issues at the workplace and generating innovative solutions for changing the ways and the future of work.

Based on these premises, the organizers and the attendees of this conference, calls the academia, researchers, employers, workers, NGOs, civil society as a whole, and governments as a whole, to act for protecting and improving mental health at work, and reaffirm their commitment to contribute to building healthy, productive, happy, and resilient societies for the generations that will follow us in the coming decades.

For more information on the 6th annual ICOH-WOPS meeting, please visit: <https://condor.zaragoza.unam.mx/wops>

Let's fire the Cult of "Boom → PTSD" and improve veteran reintegration into the modern workplace

Unskilled and shiftless heroes, drifters and potentially violent criminals, suicidal substance abusers invariably afflicted with severe psychological problems whom many prospective employers view as inflexible order-takers lacking innovation and unable to adapt to modern workplace demands.

According to surveys of human resource professionals (e.g., Overman & Leonard, 2010) and the general public (e.g., Hoit, 2015; Kulka, 1990/1988; Phillips, 2015) these are among the most enduring negative associations of the "broken veteran" archetype Americans have held since at least the Vietnam War (1954-1975). Yet, decades of research show that over two-thirds of the men and women who complete their military service return to their families, communities, and society without significant functional impairment - even after surviving multiple deployments (Bonanno, Mancini, Horton, Powell, LeardMann, Boyko et al., 2012). While many employers hire veterans for their technical, communication, and leadership skills (Harrell & Berglass, 2012) many more fear importing PTSD into their pristine civilian milieu (e.g., Stone & Stone, 2015) despite our proven resilience, resourcefulness, and professionalism (Bonanno et al., 2012; Hoit, 2012).

In my research I call the pervasive societal misconception of a main effect of warzone military service on post-deployment mental health, "Boom → PTSD" (Brady, 2017). However, to be fair, much of the durability of the "Boom → PTSD" myth resides in pop-culture fantasies of veterans as "walking time bombs" (Harrell & Berglass, 2012) and early fear-conditioned learning models of *avoidance* (Mowrer, 1956). Both of which miss how PTSD's interactive complexities develop over time (Solomon & Mikulincer, 2006). While analysis of daily newspaper war coverage estimated "mentions" of mental or physical injury among Gulf War-era II ("post-9/11") veterans at 73% (Kleykamp & Hipes, 2015), less well dissected are the covert forces driving joblessness among this cohort that peaked at 15.2% (2011) before dropping to 4.9% (April, 2018). Eclipsing the non-veteran rate of 3.5% (U.S. Department of Labor, 2018). Not surprisingly, in a large corporate poll (Prudential, 2012), 2/3rds of working-age veterans (69%) said "finding a job" was their "greatest challenge".

In fact, today's veterans enjoy record levels of concentrated, federally-funded "programmed support" and generous tax breaks for employers who hire them (Brady, 2017). So why, then, does landing a job top the list of biggest hurdles for 2 in 3 ex-service members? My best guess is that no one has asked employers, "How well do you retain the veterans you hire?" Nor asked of veterans, "How easy is it to get a 'real' job and keep it once you've gotten it?"

As a burnt out junior college counselor and Iraq war pal once put it, "No one knows how to create a vet friendly workplace that *doesn't f__k* with us." For years, I never fully grasped what that meant until a European professor warned me late one afternoon, after I asked for an extra day to cram for an exam before a weekend drill with my reserve unit, "You can't be in the military and be doing something like going to graduate school!" The irony lost here, on at least one of us, *being that our school was founded to serve returning GIs during WWII*. And now, apparently, bigots.

Before I continue to locate much of the problems of reintegrating veterans within the social environments they return to, here's a brief take on the "work attitudes" perspective. The *negative work attitudes* hypothesis predicts that the unrealistic expectations of jobseekers long on military experience and short on civilian work histories, education and transferable military skills, who are emotionally habituated to working in highly valued military occupational specialties alongside gung-ho platoon mates, results in a kind of "Culture Shock" and slow disengagement when their perceptions of low-value civilian labor become hardened by futility. In a wage-stagnant economy (Economic Policy Institute, 2018) of McJobs, thinking that your dead-end Uber gig without bennies sucks - compared to the thrill of clearing roadside bombs in Kandahar for five grand-a-month, tax-exempt in-between free cherry pie - may sharpen the contrast between the gauzy nostalgia of fading military glory and a cold and rudderless civilian subsistence engulfed by hard work, meaningless poverty, and deafening isolation.

Life sapping McJobs, however, do not typically offer stable career paths for adults desiring a career (e.g., Allan, Bamber, & Timo, 2006). Nor do other demanding and isolated jobs with low social support (i.e., "iso-strain") that are strangely common among large swaths of veterans. While making McJobs more fun, profitable and satisfying is a vital organizational outcome when it comes to the employment retention of veterans "job crafting" and "enrichment", and other stabs at increasing engagement through "work redesign", will only get us so far without first exposing the structural inequalities that bedevil veteran success in the workplace before they even show up. Research into stereotypes such as the "damaged" and "incompetent" war veteran tell us that intergenerational beliefs are shaping the reintegration experiences of the millions of service men and women who reenter the civilian job market in the prime of their lives. And this clash of perceptions and expectations with reality biases social interactions that may affect the veteran reintegration process, potentially influencing the course of post-deployment health. We live in an era where—when the White House is not belittling the voice of a dying statesman—it's now ok for a retired Air force "Blue Falcon" to go on TV and slander the honorable record of that selfsame former POW with allusions to "songbirds". This is America now.

In a beguiling experiment on how subtle interpersonal interactions and status impact stigma and social influence, college students were tricked into believing they were collaborating with veterans in three conditions: (1) military service without deployment, (2) deployment to a warzone, and (3) hospitalization from warzone PTSD. Compared with controls, Hipes and colleagues (2015) found perceptions of military service without deployment increased social influence whereas deployment to a warzone and a PTSD label decreased a veteran's social influence. Interestingly, prior military contact moderated the impact of status loss for veterans afflicted by PTSD. Social rejection from stigmatization was unfounded. Although, low power may have missed such effects. The practical significance of these preliminary findings for applied psychologists and con-

Continues on page 10



Gil Brady, PhD

"DECADES OF RESEARCH SHOW THAT OVER TWO-THIRDS OF THE MEN AND WOMEN WHO COMPLETE THEIR MILITARY SERVICE RETURN TO THEIR FAMILIES, COMMUNITIES, AND SOCIETY WITHOUT SIGNIFICANT FUNCTIONAL IMPAIRMENT - EVEN AFTER SURVIVING MULTIPLE DEPLOYMENTS (BONANNO, MANCINI, HORTON, POWELL, LEARDMANN, BOYKO ET AL., 2012)."

"IN A LARGE CORPORATE POLL (PRUDENTIAL, 2012), 2/3RDS OF WORKING-AGE VETERANS (69%) SAID "FINDING A JOB" WAS THEIR "GREATEST CHALLENGE"."

**Let's fire the Cult of "Boom → PTSD" and improve
veteran reintegration into the modern workplace (continued)**

cerned business leaders striving to build greater equity, empathy, and opportunity for veterans are crucial for several reasons.

First, low status is linked with lower chances of gainful employment, greater negative emotions within groups, and lower levels of help from others. In other words, veterans deployed to Iraq or Afghanistan face greater risk of being treated as less competent and less worthy of receiving the standard benefits of civil society as those veterans perceived as having never survived combat. This is also consistent with an audit study of hiring patterns among combat veterans that reported a *less preferential treatment bias* from employers regardless of veteran race or ethnicity (Kleykamp, 2009). Second, while still thinking about how twisted all that is, consider that at least one-quarter of PTSD cases are late onset, which suggests that for some newly-minted veterans the reintegration process may be determinative of whether they acquire PTSD. Third, four decades of lifespan research (e.g., Marmar, Schlenger, Henn-Haase, Qian, Purchia, Li et al., 2015) with Vietnam veterans shows that warzone-related PTSD can follow a chronic course that places veterans at higher risk of premature mortality from chronic diseases (e.g., cardiovascular, diabetes) and other behavioral causes (e.g., injury, suicide, overdose). As if that were not enough, Southeast Asia combat veterans with PTSD were nearly twice as likely to have died as Vietnam-era veterans without PTSD who did not deploy (Schlenger et al., 2015).

Somewhere, I can hear a practicing organizational psychologist committed to designing effective and compassionate occupational health interventions tapping their nails.

Industrial-organizational psychology research is beginning to test specific hypotheses on helping military veterans readjust to the modern workplace that clinical research by design cannot. In my small cross-sectional study of modifiable factors among 382 working post-9/11 veterans living in the Pacific Northwest, unsurprisingly I found that the quality of a veteran's sleep attenuated the influence of combat experiences on symptoms of PTSD (PTSS). More curiously, I also found support for my main hypothesis (Figure. 13) that *iso-strain jobs* also moderated this relationship, acting as an *enhancer* of combat on PTSS. Where, greater *iso-strain* predicted more posttraumatic stress. Unfortunately, one of my study's many limitations was that sleep was measured retrospectively and may therefore be a proxy for depression (Brady, 2017). Nevertheless, I still find myself obsessing over what it is about *iso-strain jobs* that may attract veterans while also placing them at greater risk of mental and physical illness.

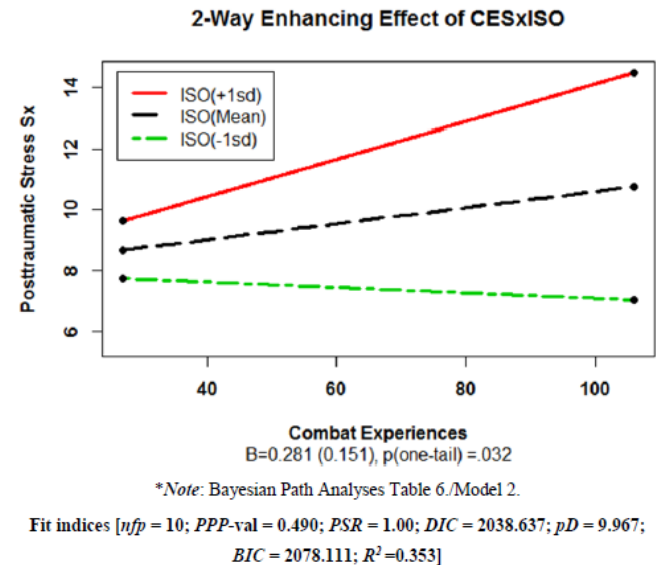
My hunch is that for those veterans who do not self-select into such obvious *iso-strain situations* as graveyard workers, truck drivers, and Port-a-John technicians, unchecked biases (e.g., Zoroya, 2013) among HR professionals, recruiters, educators, middle managers, and supervisors steer those tagged with PTSD into even more high-risk and isolated work (e.g., helicopter cowboys) - where liability is limited and blame is easy to shift - when not simply burying their applications in the trash. Until future research uncovers how veterans land in particular civilian occupations, some general recommendations for business leaders seeking to better the odds of success for their veteran employees include:

Improving communication among workers and supervisors: One low-cost avenue for improving perceptions of collegial support to reduce risk of strain is utilizing freely available communication/messaging software systems (e.g., "Hip-Chat") to better connect and integrate organizational-wide telecommuters and shift workers with onsite staff and supervisors in one multi-topic platform compatible with computers and smartphones.

Practicing consistent sleep hygiene: Obtaining healthy sleep is vital to maintaining physical and mental health, including PTSD. Regular healthy sleep habits (e.g., avoiding caffeine and nicotine before bed) can also improve productivity and quality of life. Everyone can benefit from practicing good sleep habits and supervisors, coworkers, and family members can all improve their sleep by modeling consistent healthy sleep routines. For more information on best recommend "sleep hygiene" practices from the *National Sleep Foundation* please click [here](#).

Increasing job control: For veterans and other workers adapting to the civilian workforce with physical disabilities, cognitive impairments, and emerging psychological symptoms the role of modern assistive technologies (e.g., screen reading software, Braille displays, alternative interactive devices) may enhance end-user experiences while increasing perceptions of job control, which may reduce risk of job strain and posttraumatic stress. Also, higher perceived job control may follow organizational allowances for greater employee schedule flexibility to keep medical appointments and promote worker health.

Figure 13. Combat Experiences x Iso-strain on symptoms of posttraumatic stress



"IN MY SMALL CROSS-SECTIONAL STUDY OF MODIFIABLE FACTORS AMONG 382 WORKING POST-9/11 VETERANS LIVING IN THE PACIFIC NORTHWEST, UNSURPRISINGLY I FOUND THAT THE QUALITY OF A VETERAN'S SLEEP ATTENUATED THE INFLUENCE OF COMBAT EXPERIENCES ON SYMPTOMS OF PTSD."

**Let's fire the Cult of "Boom → PTSD" and improve
veteran reintegration into the modern workplace (continued)**

Compensation, wages, and job-related training: As perceptions of "effort-reward imbalance" predict stress-related disorders (Siegrist, 1996) aligning veteran pay scales and compensation packages with their non-veteran coworkers in comparable positions should be a top priority.

Promoting culture change: Executives, hiring managers, supervisors, and coworkers need to understand that impaired attention, gaps in memory, and feelings of detachment are common reactions to trauma (e.g., traumatic brain injury) and that low social support is a known risk factor for full-blown PTSD. Moreover, promoting increased contact with military members may reduce stigma and stereotypes and enhance performance of veteran skills and ability.

Uncovering the biopsychosocial process underlying how the civilian work milieu shapes PTSD and predicts veteran retention, job satisfaction, and other outcomes of interest will require novel interventions tested against more complex longitudinal organizational designs within multilevel, randomized-control studies (e.g., Brady & Hammer, 2013). At a societal level, supervisors, coworkers, and industry leaders all have vital roles to play in enhancing the quality of life of their veteran colleagues and coworkers. By rejecting the insidious cult of "Boom → PTSD", we have already launched this all-American moonshot.

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"AT A SOCIETAL LEVEL, SUPERVISORS, COWORKERS, AND INDUSTRY LEADERS ALL HAVE VITAL ROLES TO PLAY IN ENHANCING THE QUALITY OF LIFE OF THEIR VETERAN COLLEAGUES AND COWORKERS. BY REJECTING THE CULTISH DOGMA OF "BOOM→PTSD", WE HAVE ALREADY LAUNCHED THIS ALL-AMERICAN MOONSHOT."

Successful Management of Employees with PTSD in the Workplace*

By Shana Palmieri, MSW

With 8 million adults experiencing Post-Traumatic Stress Disorder (PTSD) in a given year, 7-8% of adults have PTSD at some point in their lifetime, and rates as high as 20% in a given year for veterans, chances are you have employees with PTSD - or at a minimum, employees who are suffering from symptoms of PTSD (Gradus, 2017).

First, what is PTSD?

Post-Traumatic Stress Disorder is classified as an anxiety disorder which changes the body's reaction to stress, affecting stress hormones and specific parts of the brain. PTSD can develop in individuals that have experienced a life-threatening event (such as combat), a natural disaster, sexual assault, a car accident, or even witnessing a life-threatening event.

It is important to note that not all individuals who experience a life-threatening event will develop PTSD. In fact, 70% of adults in the U.S. have experienced some type of traumatic experience in their lifetime; that is 223.4 million of us! Of that 70%, only 20% will go on to develop PTSD, or approximately 44.7 million people in the U.S. At any given time, around 8% of people in the U.S. have PTSD. That translates to 24.4 million people, roughly the population of Texas (PTSD United, 2013).

Individuals that develop PTSD as a result of experiencing life-threatening events develop specific symptoms, to include the following:

- Intrusive thoughts, nightmares, flashbacks, emotional distress to traumatic reminders, physical reactivity to traumatic reminders
- Avoidance of trauma-related stimuli
- Exaggerated self-blame, social isolation, difficulty connecting with others
- Irritability, difficulty sleeping, fatigue, heightened startle reaction, difficulty concentrating, hypervigilance

What does PTSD in the Workplace Look Like?

PTSD is much more than an individual reacting to loud noises that sound like gun shots or bombs going off. The interactions that trigger PTSD symptoms can be subtle and difficult to understand for individuals who have not had the experience themselves. It could be something as simple as someone putting their hand on a colleague's shoulder. What may be a non-threatening gesture to one person, may trigger a strong emotional and physical reaction in another individual as a result of past experiences. A supervisor that has a "strong tone" may come across aggressive or trigger an employee with a history of verbal and physical abuse.

It is important for supervisors, managers and human resources staff to listen and openly communicate with employees to ensure a work environment that creates a place where the employee feels safe and has the opportunity to be successful in their position.

Is PTSD Real?

There is an unfortunate common misperception that PTSD is not a real disorder. Research has demonstrated both through changes in the brain and changes in stress hormones that in fact, people with the diagnosis of PTSD have significant brain and hormone changes compared with individuals that do not have PTSD. These changes are directly related to the symptoms individuals with PTSD experience. So yes, PTSD is very real and so are the symptoms individuals are experiencing as a result. An individual with PTSD has a disability and is legally entitled to the reasonable accommodation process.

How can Employers Create Opportunities for Success for Employees with PTSD?

- Ensure all supervisors, managers and human resources staff are educated on the symptoms of PTSD and the potential impact on the workplace.
- Learn to recognize the warning signs that an employee is struggling and provide support and guidance to help them access treatment options.
- Encourage and support employees in accessing EAP and appropriate mental health services.
- Implement programs through HR or EAP that promote mental wellness and stress reduction.
- Engage in the interactive process to determine what workplace accommodations need to be made for an individual with PTSD.

For more on this, attend FELTG's seminar [Federal Workplace Challenges: Behavioral Health Conditions, Threats of Violence, and Coworker Conflicts](#) July 17-19 in Washington, DC. Info@FELTG.com

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Shana Palmieri, MSW

"WITH 8 MILLION ADULTS EXPERIENCING POST-TRAUMATIC STRESS DISORDER (PTSD) IN A GIVEN YEAR, 7-8% OF ADULTS HAVE PTSD AT SOME POINT IN THEIR LIFETIME, AND RATES AS HIGH AS 20% IN A GIVEN YEAR FOR VETERANS, CHANCES ARE YOU HAVE EMPLOYEES WITH PTSD - OR AT A MINIMUM, EMPLOYEES WHO ARE SUFFERING FROM SYMPTOMS OF PTSD (GRADUS, 2017)."

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 K G V Q E C N E I L I S E R G H G H
 F N O I T A N I M I R C S I D X O I
 E R G O N O M I C S S S E R T S B U
 S N J O V P S Y C H O S O C I A L Z
 D L I F E N E I G Y H P E E L S O W
 S B D W E E C A L P K R O W B G L B
 T Q T L L N B Q I U X C O O K T A H
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 G X V B M M H H T W G K Z O K M N L
 G K W W A M M K Y I E M P L O Y E E

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The Society for Occupational Health Psychology is a non-profit organization with the purpose of engaging in activities to instruct the public on subjects useful to the individual and beneficial to the community. These efforts are achieved (1) by obtaining, and disseminating to the public factual data regarding occupational health psychology through the promotion and encouragement of psychological research on significant theoretical and practical questions relating to occupational health and (2) by promoting and encouraging the application of the findings of such psychological research to the problems of the workplace.

For comments on the newsletter or submissions please contact the Editor:

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