FALL 2007 • VOL. 2, NO. 3

DIVISION 56

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

NEWSLETTER

A View Inside

Presidential Voice

Trauma of Illness

Judie Alpert

Greetings,

I just returned from the APA convention. It was a wonderful meeting, and I am thrilled about all the activity ongoing within our division. That is the bottom line! Following is an abbreviated version of the presidential address I presented at that meeting on August 18, 2007.

Judie Alpert, PhD

Before his death, Anatole Broyard was the New York Times daily book critic and a frequent contributor to the *New Yorker* magazine. He was born to a Black family in New Orleans in 1920 and spent his childhood in Bedford-Stuyvesant, an area of Brooklyn, New York inhabited, at the time, mostly by impoverished Black people. Neither of Broyard's parents had graduated from elementary school.

In his 20s, Broyard chose to obscure his past. He lived the life of a reinvented White man for almost five decades. He wanted to pass as a White man, and he was able to do so. His light skin and short hair enabled him to pass.

Why did he choose to pass? He wanted to evade categorization as "a Black writer" and, instead, be noticed as "a writer." Did he truly pass? He was married to a White woman. They had children. None of his children knew that he or they were Black. So, yes, he passed. Yet, while he was passing, he could not keep his own secret. His writing reveals what he was trying to hide as it focused on the act of masking a past and a self.

Passing is not a new concept. There are many stories of passing. These stories exist as nonfiction and as fiction (e.g., Philip Roth's *The Human Stain* or Henry James' *Portrait of a Lady* or F. Scott Fitzgerald's *The Great Gatsby* or Theodore Dreiser's *An American Tragedy*).

People who are Black may choose to pass as White. People who are gay may choose to pass as heterosexual. People who are Jewish may choose to pass as Protestant, and so on. In general, the term "passing" is used to refer to these and similar maskings. At this point you may be wondering why the title of this paper focuses on illness.

The concept I want to place on the "trauma map" is: "physically ill people passing." "Passing" here does not mean

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FROM THE EDITOR

Dear Div. 56 Members,

What a wonderful treat to meet so many of you in San Francisco at the Annual APA Convention and to have the opportunity to personally thank you for contributing, in a variety of ways, to the TRAUMA **PSYCHOLOGY** NEWSLETTER.

Topher Collier, PsyD, ABSNP

For those of you who were able to attend, I am sure you share with me in thanking those who presented at the conference. There certainly was much to take in, process, and discuss with such a collective—and collaborative—gathering of academics, practitioners, and policy makers. For others who were unable to partake and celebrate in the one-year birthday of Division 56 at this year's conference, we look forward to spotlighting highlights of our division and the convention programs in upcoming issues of TRAUMA **PSYCHOLOGY** NEWSLETTER.

In the meantime, please remember to keep those submissions and letters of opinion coming!

Topher Collier, PsyD, ABSNP
Editor, TRAUMA **PSYCHOLOGY** NEWSLETTER
Division 56 of the American Psychological Association

Winter 2008 Issue

The *Trauma Psychology Newsletter* is accepting articles for the Winter 2008 issue. The deadline for submissions is **December 15, 2007**. Suggested article length is 1,500 words, submitted in MS Word or Wordperfect formats. Submit articles for consideration to Topher Collier, Newsletter Editor, at DrTopherCollier@aol.com.

Also, any publications within 2007 by Division Members should be sent to Kathy Kendall-Tackett (KKendallT@aol.com) by this date, too, as we are planning to include a list of member publications as well.

VISION AND VOICES

Accomplishments for 2007

Robert Geffner, PhD, ABPP, ABPN, President-Elect, Division 56
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It is a pleasure to follow in the excellent footsteps of our initial president, Judie Alpert. Much of the initial activities and organization needed for a new division has now been established, but some additional tweaking is still necessary. Our continuing Board members and new ones take office officially on January 1, 2008. We have an excellent executive committee as noted elsewhere in this newsletter, and I am honored to work with them for the coming year.

We have come a long way in a year! Our first convention with programming was quite an accomplishment, and kudos to Steve Gold and Joan Cook who organized it. Our first major Board meeting with most of the committee chairs, our first Presidential address, our first hospitality suite, our first awards ceremony, and our first election under APA auspices occurred. Many committee chairs were appointed and we began work on several fronts. In addition, in our first year we were accepted as the 11th Division in the Divisions for Social Justice. We also enjoyed a Dessert reception at the convention with Divisions for Social Justice and the Public Interest Directorate, co-sponsored by Haworth Press. We had over 350 people attend this event, and had our first silent auction of books to raise funds for the Division. The Auction was organized by Kathy Kendall-Tackett and Emily Jacobs. Our thanks go to the publishers and authors who donated the books for this.

Robert Geffner, PhD, ABPP, ABPN

In our first full year, we have already surpassed 1,100 members, and we just missed (by less than 50 points) having two members on the Council of Representatives! We were involved in three CODAPAR grants with other divisions, and began pursuing a journal for the division. Members of the Division have been involved in many activities, including media stories about different aspects of trauma. It is difficult to comprehend how far we have come in such a short time.

Goals for 2008

However, we cannot relax on these accomplishments. For the coming year, many goals have been set for my presidential initiatives. Depending upon how many people listed Division 56 as their main one at the conference last August, we may gain additional program hours. We plan to have more activities in the hospitality suite next year.

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My goals for 2008 include:

- 2,000 members by the end of 2008;
- An increased financial reserve in our budget and bank account;
- An even larger role in the APA convention programming;
- Acceptance of a contract for a journal for the Division;
- Increased use of our listserv and most of our members included in it;
- More students and early career psychologists involved in the Division.

I have also set specific initiatives for 2008. The task force for monitoring and providing feedback on *DSM-V* will be continuing next year, as will the ones on Coercive Interrogations and Torture and also Trauma in the Military. It is hoped that preliminary recommendations can be made by these chairs at our mid-winter meeting the beginning of March, 2008. Additional recommendations should be provided by convention next year.

As far as other major activities, I have set two content areas for my initiatives: The Traumatic Effects of Violence and Abuse in Interpersonal Relationships, and The Ethical Role of Psychologists in Dealing with Trauma in Forensic Settings. With respect to the first initiative, Division 56 is the lead co-sponsor, with Division 35, of the Mid-Winter **Summit on Violence and Abuse in Relationships: Connecting Agendas and Forging New Directions**. I am co-chairing this Summit with Jackie White, President of Division 35. This Summit is included as part of Alan Kazdin's APA Presidential initiatives, which means APA has been involved as well. In addition, 14 other divisions of APA are collaborating on this major event along with several other agencies and organizations. Please see the announcement in this issue of the newsletter. Division 56 will have a major role in this Summit, and that it will become a bi-annual interdivisional event in even-numbered years (the Multicultural Summit occurs in odd-numbered years). I hope many of you attend this important summit. The first day includes legislative advocacy conducted by the Public Interest Directorate, and five members of each of the divisions will be trained and then taken to Capitol Hill to meet representatives of Congress.

Using a combination of plenary speakers, break-out groups, and a town hall, the Summit offers participants the opportunity to interact with experts in many fields to address critical issues regarding relationship abuse and violence. The goal is to facilitate dialogue among those with diverse interests and experiences in order to generate recommendations for research, intervention, and prevention on topics such as intimate partner violence, child maltreatment, children's exposure to violence, elder abuse, date rape, the role of gender, culture, and intersecting identities and vulnerabilities for victimization, substance use, and integration of the different types of violence.

The Summit is just the first step of a concerted effort to have an impact on reducing violence and abuse in relationships. We plan to follow this up with a mini-convention on this topic at the convention in Boston as part of Alan Kazdin's initiative, and other divisions will be involved as well, such as Divisions 35 and 48. Then in September, there will be a think tank prior to the **13th International Conference on Violence, Abuse and Trauma** in San Diego that will focus on Policy Issues and recommendations for Research, Practice, and Prevention efforts to reduce violence and abuse in relationships. Various products will be a part of this initiative.

The second content initiative concerns the interaction of trauma and forensic psychology. Trauma has become an important issue in many situations that end up in courts, such as intimate partner violence, child maltreatment, elder abuse, and child custody cases. Too often, psychologists and other mental health professionals conduct forensic evaluations of those who have been traumatized, and/or testify in court as expert witnesses about issues related to such traumas, without having the appropriate expertise or experience in trauma psychology, violence, and abuse. In such situations, diagnoses, conclusions, and recommendations may be incorrect or not appropriate due to the lack of such training in trauma psychology and related areas. Ensuring that psychologists who work in such settings are adequately trained and practice ethically will be one of my emphases next year.

I look forward to an exciting year for the Division, and encourage all of you to become active in the Division as well as recommending that your colleagues join us. Please feel free to contact me (bgeffner@pacbell.net) if you have questions or concerns, or to give us ideas for accomplishing our ambitious agenda for 2008.

TRAUMA AND HEALTH

Shadows of Disintegration: Chronic Shock

Kathleen Adams, PhD
Independent Practice

Marilyn was a 30-year old company CEO who *loathed* group therapy. She said I ignored her and gave preferential treatment to all the other group members. Worse yet, she could hardly stand to look at me because I resembled the Wicked Witch of the West. For 4 years, she had been gamey, sulky and non-communicative in group. I knew from her individual therapist that she desperately longed for my "eyes," my warmth, yet whenever we tried to engage one another, I felt rebuffed, inadequate, incompetent. I would catch her eyes and smile the moment she walked into the group room and she would light up, only to descend into haughty frozenness once group began. She spoke in rote, distant, intellectualized manner that was perplexing, given the vulnerability she brought to her individual therapy. She confided to her therapist that she had fantasies of throwing herself down my stairs to compel my concern, but would become blank and dismissive when I asked her about these fantasies. She knew that her therapist and I discussed her progress on a weekly basis. Since she was working actively in individual therapy about the agony she experienced with me, but was "playing hard to get" with me in group, I allowed her to wrestle silently with her ambivalence, inviting her to share her disappointments in me but not pressing the point when she chose to be dismissive. I thought of her as an entrenched, "help-rejecting complainer," a quiet borderline who was stuck in a re-enactment of her early childhood with me. A bit of background: when Marilyn was one her mother had another baby. Simultaneously, the mother became gravely ill and was bed-bound for 2 years. During Marilyn's toddlerhood she had to gaze distraughtly from the floor at her mother holding the new baby; she was not big enough to crawl up on the bed nor could her mother reach down and pick her up. She was nearsighted and could not see her mother's eyes.

Marilyn gradually began to thaw towards other group members and interacted warmly, but maintained the "ice queen" façade with me. One evening she shared a dream in group: a botanical garden had a rare and beautiful species of tree, lush with multicolored flowers and delicious fruit. The tree was slowly dying, however; unbeknownst to the caretakers, the ground beneath the apparently healthy tree was frozen. The roots beneath the tree were rotting, starving, and desperate for nurturing attention. This dream heralded a major shift in our work together. As I listened to this dream I realized Marilyn was not so much characterologically disturbed as she was quietly dissociative (DDNOS). She struggled with vertical splits: while part of her was an over-intellectualized executive, another part of her was a frantic toddler, with fractured affects and concrete thinking.. I thanked her for her dream and told her that I suddenly understood that I had been torturing the "baby" in her all these years, and that I was deeply sorry. She burst into a heartwrenching, undefended wailing of rage, terror and tears. In vulnerability and confusion she asked why I was being nice to her *now* when I used to watch her fall and fall without trying to catch her. She turned to the group to ask why they hadn't said something all those times she obviously shattered into pieces in group. The group members explained that they were startled to find out that she was suffering, that she always looked quite "together" if somewhat irritated with my incompetence. I told her that if I had *known* there was a frantic two year old inside of her trying to get out, I would never have left her to die in the cold, frozen ground; that I had presumed she had the skills to come to me since she was so sophisticated in many other respects. She was fascinated to learn that she looked so different on the outside then she felt on the inside, and realized that she had to learn to take better care of the submerged parts of her self. Over the next few months she learned to work with the young emotional self inside her, identifying burgeoning rage and terror states and concrete thinking. She took the risk of bringing the rage and terror into the group, as she learned to recognize and share which ego state perspective she was talking from. From the outside one could see and sense her wrestling with cognitive confusion and thinking errors as grew in her confidence to manage the profound feelings that used to terrify and overwhelm her. Her "young self" began to grow up as Marilyn allowed herself to experience the ravages of early deprivation.

Like Marilyn, many high functioning patients without history of overt trauma, abuse or blatant character pathology develop dissociative traits, autistic enclaves, and vulnerability to disintegration, relationship dysfunction and addictions. Five other non-abused patients in the same group as Marilyn eventually revealed covert dissociative functioning (Adams, 2006). Clinicians as a group are largely unaware that a lifelong vulnerability to fragmentation, shattering and accumulations of chronic shock disrupts one's capacity for the experience of pleasure across neurological, developmental, and cognitive dimensions (Migdow, 2003). Why do these patients live in the chill of chronic apprehension, to the detriment of their ability to truly relax into peacefulness, play and the pursuit of deep contentment? These are the compulsive caregivers and high achievers whose success masks subtle DDNOS states, complex PTSD and chaotic relationships. In the course of depth therapy these individuals reveal covert primitive self states existing in parallel with sophisticated, mature functioning. We need to expand our definition of trauma to incorporate early traumatic experiences that may be encoded preverbally. Many of my covert dissociative patients had parents or sibs who were struggling with serious debilitating illness, such as cancer or meningitis, or had themselves experienced medical traumatization in childhood. Even in the absence of direct abuse or neglect, the cumulative trauma of chronically uncontained distress during early childhood manifests later in complex PTSD, insecure attachment patterns, subtle dissociation, and low thresholds for fragmentation and catastrophic anxiety. Perplexed by a bewildering blend of strength and vulnerability, these patients are quite relieved when they come to understand that some of their more problematic behaviors and decisions have been driven by immature ego states they were unaware of. These ego states oscillate between terror of intimacy and desperate need for human contact, striving to insulate themselves from the vulnerability and vagaries of being human (Mitrani, 1996). Myers (1940) first described these alternating states as the "emotional personality" (EP) and the "apparently normal personality"(ANP). Nijenhuis and van der Hart (1999a, 1999b) have integrated Myers' concepts with cutting edge breakthroughs and innovation from the fields of neuroscience and traumatology to provide a powerful model for current-day understanding of subtle dissociative processes. The 'emotional memories" of the "emotional personality" tend to be experienced as intense waves of feelings accompanied by visceral and kinesthetic sensations such as sinking, falling, exploding, and the like. Lacking the internal shock absorbers of securely attached individuals, the covert dissociative patient is vulnerable to emotional flooding and disrupted functioning under conditions of stress(Liotti, 2004). Catastrophic anxiety states encoded in preverbal, implicit memory, surface without any sense of being from the past and underlie behavioral choices and strategies, especially within relationships.

Disorganized Attachment

Disorganized/disoriented attachment is the characteristic attachment style of children who experienced chronically misattuned, unpredictable, and frightening

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Shadows of Disintegration

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or frightened parenting; these children are at high risk for developing dissociative defenses (Liotti, 2004; Schore, 2002,2003). Most importantly, emotional repair of distressing interactions was nonexistent. Even in the absence of direct maltreatment, when parents have unresolved, partially dissociated traumatic anxiety that they transfer to their infants through subtle, behavioral and emotional cues, their infants are seemingly unable to develop an organized attachment strategy (Hesse & Main, 1999). Instead these children develop disorganized internal working models with multiple, contradictory, and alternating dimensions, along with a vulnerability to catastrophic anxiety states. The simultaneous need for and fear of the caregiver disorganizes the infant's ability to seek and accept soothing from the parent as a solution to stress and fear. *It is these unbearable, chronic affect states of being abandoned, unprotected, confused and frightened by a significant other who cannot relate helpfully to the child's distress that I characterize as attachment shock.* Marilyn had given up on me as a reliable source of soothing and containment. Since the brain is an "anticipation machine," scanning the environment and trying to predict what is coming next (Siegel, 1999a, 1999b) these disorganized youngsters become adults who are hypersensitive to the moods of others: "emotional meteorologists." Marilyn talked frequently about her sensitivity to being on another's radar.

The cumulative trauma (Khan, 1974) of subtle traumatization in childhood has great potential for intergenerational perpetuation of "fear of breakdown" (Winnicott, 1974), even in individuals with no conscious remembered experience of breakdown or abuse. (Hesse & Main, 1999). In a recent study of children of mothers suffering from anxiety disorders, 65% of offspring had disorganized attachment (Manassis, Bradley, Goldberg, Hood, & Swinson, 1994). Repeated entrance into disorganized/disoriented states in infancy, what Hesse and Main term *fright without a solution* (p. 484), may then increase the risk of catastrophic anxiety states, paranoid states, DDNOS, and other manifestations of fear of breakdown in the adult patient, even in the absence of overt trauma history. Winnicott's longstanding belief that "fear of breakdown" is really terror of something that has already been experienced in the past now has validation from neuroscience.

Shock States: Of the Body, Not the Mind

The shock of the sudden, the random, in an attachment relationship can have staggering impact. Bollas (1995) describes the devastating impact of the random and unexpected attachment shock that can be triggered by the relatively innocuous occurrence of a parental blowup, even on the mind psyche of a child with secure attachment:

> Every child will now and then be shocked by the failure of parental love… But when a parent is unexpectedly angry with the child…the child's shock may result in what seems like a temporary migration of his soul from his body. This is not a willed action. It feels to the child like a consequent fate, as if the parent has blown the child's soul right out of his body. Each of us has received such an apprenticeship experience in the art of dying. We know what it is like for the soul to depart the body even though we have as yet no knowledge of actual death…Each adult who has had "good enough parenting" will have a psychic sense of a kind of migration of the soul, sometimes shocked out of the body but always returning. This cycle of shocking exit, emptiness and return gives us our confidence, so that even when we are deeply disturbed by traumatic events…we feel that somehow "it will turn out all right in the end. (p. 215)

If even occasional shock states under conditions of secure attachment are shattering, what impact might repetitive shock states have on the developing child? When mental states become "engrained" in the body/mind by repetition, they become more and more likely to re-occur: "Neurons that fire together, wire together" (Hebb, 1949) to form states of mind (Siegel, 1999a). Neuroscience tells us that these early fear experiences are practically indelible:

> Repeated experiences of terror and fear can be engrained within the circuits of the brain as states of mind. With chronic occurrence, these states can be more readily activated(retrieved) in the future, such that they become characteristic of the individual. In this way our lives can become shaped by reactivations of implicit memory, which lack a sense that something is being recalled. We simply enter these engrained states, and experience them as the reality of our present experience.. (Siegel, 1999a, pp.32).

Attachment shock is the cumulative trauma resulting from chronically uncontained distress; as shock states become increasingly engrained and dissociated, they may evolve from transitory states of mind into encapsulated, specialized sub-selves, whose purpose is to assist in insulation and recovery from shock.

Neuroscience has taught us that implicit relational knowing develops from the first months and years of life, largely outside the arena of symbolic or verbalized knowledge. (Siegel,1999a, 1999b). Cognitive science suggests that "*implicit processing may be particularly relevant to the quick and automatic handling of nonverbal affective cues*." (Lyons-Ruth, 1999) I believe the superfast, supercharged early physiological warning signals of burgeoning attachment shock initiate the transitory paranoid states we so often encounter in individual, group and couples therapy.
These rapid state shifts are where preverbal, presymbolic experience comes in. Preverbal experience by definition has not yet been thought about but only lived in the body of the person experiencing it, like Bollas' "unthought known."

The Fractured Container and DDNOS: Chronic Shock

Bion (1962) taught us that a "stepping stone" in the normal development of a child is having the experience of a "container" to receive and process the jumble of feelings and sensations, mainly painful ones but also painfully excited ones, that the child's brain eventually needs to learn how to regulate. Bion stressed that it is vital for the mother to use her own mental, emotional and physiological resources for giving a meaning to the meaningless, as the child has no resources of his own as yet outside of his environment. What happens, then, when the container repeatedly fractures; when the parent shouts in reaction to a child's wails; when a parent goes cold as ice as the sobbing youngster reaches for a hug;

when a parent breaks off contact during a child's meltdown? Shock response occurs naturally when we experience life threatening anxiety (Levine, 1997) and takes its toll on the nervous system of infants who are stressed, leading eventually to dissociation (Porges,1997, 2001). We now know from neurobiology that infant dissociation "is a consequence of a 'psychological shock' or prolonged high arousal" (Meares, p. 1853, in Schore, 2003).

The key component to collaborative problem solving is the ability to negotiate mind to mind. Siegel's (1999, 2003) work on the nascent sense of self suggests that it is in mind to mind emotional limbic resonance that we learn who we are, how to feel, and how to regulate how we feel. An inability or unwillingness to establish mind-to-mind resonance collapses the intersubjective space between parent and child and renders the child at the mercy of the parent's feelings and projections. In this situation the distressed child does not exist in his own right as a person to be consulted, or made amends to, but rather just as problem to be managed however the parent sees fit. Thus the child must rely upon his own, paltry resources for self regulation and is left to experience unbearable states such as feeling dropped, shamed, menaced, confused, disoriented, rejected or terrorized. What we see in disorganized attachment is the systematic failure of collaboration, empathy and repair on the part of the parent, *which contributes to a build-up of attachment shock in the developing child*. The child is left in confused, startled or despairing agitation for a period beyond endurance.

Krystal's (1988) work on trauma and affect reminds us that trauma, even early trauma, doesn't just overload the circuits in some mysterious neurological fashion, but is related to meaning making. While psychoanalysts may be unaccustomed to using nomenclature such as DDNOS and DID, they have a long history of studying body memories, dissociative states, autistic barriers, and encapsulated selves (Melanie Klein, 1957; Sidney Klein, 1980; Mitrani, 1996, 1997, 2001; Tustin, 1981, 1986, 1990). When parenting is "not good enough," the youngster is rendered vulnerable to randomness; he discovers he has no influence, let alone omnipotence. This discovery is shattering enough to rip a metaphoric hole in the psychic skin. The concept of the psychic skin was proposed in 1968 by Bick as a construct corresponding to the bodily skin. The psychic skin serves the function of holding the parts of the personality together. Disturbances in the domain of the psychic skin can lead to the development of "second skin" formations (Bick, 1968) through which dependence on the mother is replaced by pseudo-independence or pseudo-relating (Mitani, 1996, 2000). These patients sometimes paper over the holes in their psychic skin with encrustments, armor, intellectuality, muscularity, addictions, and athleticism. Alternatively they glom onto the surface of others in the hope they will provide sufficient bandaging to the psychic skin to prevent leaking, using people as interchangeable band aids for as long as they are available to plug the holes. The cultural phenomenon referred to as "serial monogamy" by savvy singles is often revealed, in depth psychotherapy, to be more of an attempt to staunch the flow of uncontrolled psychic bleeding with at least someone, however unsuitable, than it is a genuine search for a compatible partner. "Hole repair is what psychotherapy is all about" (Kinston and Cohen, 1986, p 337).

Black Holes and the Basic Fault

Attachment shock is a visceral metaphor for understanding the lived experience of the basic fault, and its contribution to shattering in patients who had sub-optimal parenting. Balint (1957) described the basic fault in the personality very carefully: "not as a situation, position, conflict or complex….in geology and crystallography the word fault is used to describe a sudden irregularity in the overall structure, an irregularity which in normal circumstances might lie hidden but, if strains and stresses occur, may lead to a break, disrupting the overall structure" (p. 21). By definition shock is a jolt, a scare, a startle, a fall, a sudden drop or a terror reaction; shock can daze, paralyze, stun or stupefy us. We draw a sharp, deep breath inward and almost stop breathing. As attachment shocks accumulate, so do experiences of meaninglessness. The more a youngster experiences himself as unable to forge a meaningful bond with his parents wherein he feels understood and responded to emotionally, the more desperate and bereft he feels. Meaninglessness is the link-breaker of connection (Grotstein, 1990a, 1990b) and the doorway to the "black hole" experience indigenous to trauma. "The disintegrative nature of the black hole is a chaotic state of turbulence, an experience of the awesome force of powerlessness, of defect, of nothingness, of zeroness-expressed not just as a static emptiness but as an implosive, centripetal pull into the void…" (Grotstein, 1990, p 257). Grotstein, who wrote extensively about the black hole experience, considers nothingness and meaninglessness to be the fundamental traumatic state, the most dreaded nadir human experience.

Without an active cognitive framework for working with subtle dissociative structures, we are likely to mistake dissociation for character, as I did with Marilyn. Our patients come to us already stuck, stagnant, and boxed in by their own fears, structures, and templates. Dissociative patients by definition, become disconnected from their bodily and numbed to their affective experience because feeling "what is" is so intolerable. Unfortunately it is easier to stay experience-distant instead of experience-near, as I did with Marilyn for 4 years. Even with a sophisticated background in traumatology and considerable experience working with more florid dissociative defenses, I totally dropped the ball until Marilyn brought me her dream. Marilyn had relied upon intellectuality, avoidance, musculature rigidity and an argumentative interpersonal style to plug the holes in her psychic skin. She scanned me and others continuously for the slightest hint of rejection, at which point she would collapse into a black hole of meaninglessness and silent despair. She had buried her emotional self behind a wall of impenetrability, which even she had difficulty accessing. After that pivotal group session she learned to rely upon her bodily experience to help herself identify and access the emotional turbulence of her emotional personality. She explored numerous dimensions of attachment shock, paving the way for other group members to open to their own shock experiences. She

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literally "blossomed" in group, working first her anaclitic despair about how her mother (and I) had failed her, and then moving into forgiveness/acceptance which was accompanied by a shy delight at feeling acknowledged at last, known, and appreciated. She no longer cycled in and out of paranoid states with me. Indeed, she rapidly became one of the leaders of the group, able to connect easily and confidently with others.

I owe a debt of gratitude to Marilyn: I now know to look for subtle dissociation attachment shock and vertical splits in my other high functioning patients We all too often overlook the serious implications of early neglect, accidents and illness, separations, loss, and dysfunctional families. Unless patients present with an outright abuse or disaster history, we often don't consider trauma in differential diagnosis. Bowman & Chu (2000) suggest that trauma is the fourth paradigm for understanding psychopathology, interweaving with psychodynamics, behaviorism, and neurobiology. "Until psychological trauma—especially devastating trauma occurring early in life—is incorporated into the other three paradigms of mental illness, a 'unified field theory' of mental health will elude us" (p. 10). Instead we diagnose patients in the fashion most familiar to us and insert them into our therapeutic practices, undertaking defense analysis, tackling characterological issues, exploring underlying conflicts and fantasies. That's what we were trained to do. This protocol fails to permit our patients to unfold and reveal who they really are unless we broaden our scope and think trauma, listen for parallel self states, and look underneath patients' surface presentation for the depth within.

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The Psychological Impact of Birth Experience: An Underreported Source of Trauma in the Lives of Women

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> The birth of a child, especially a first child, represents a landmark event in the lives of all involved. For the mother particularly, childbirth exerts a profound physical, mental, emotional, and social effect. No other event involves pain, emotional stress, vulnerability, possible physical injury or death, permanent role change, and includes responsibility for a dependent, helpless human being. Moreover, it generally all takes place within a single day. It is not surprising that women tend to remember their first birth experiences vividly and with deep emotion (Simkin, 1992, p. 64).

In her landmark study, Simkin (1991; 1992) described how women vividly remembered details of their first births, even 20 years later. And what they remembered had a lasting impact on how they felt about themselves as women and as mothers. Unfortunately, birth can be a traumatizing experience, with some women likening their birth experiences to sexual assaults. Yet health care providers are often blithely unaware of the havoc they have created, as Beck (2004a) observes.


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> Whereas some of the mothers in this study felt as if they had been raped, the clinicians appeared to the women as oblivious to their plight. The mothers perceived that the clinicians focused only on the successful outcomes of clinical efficiency and live healthy infants (p. 34).

Several recent studies have found that women can develop posttraumatic stress disorder (PTSD) after birth. Beck (2004b) reviewed this literature and noted that the percentage of women who met full criteria for PTSD following birth ranged from 1.5 percent to 6 percent. The study with 1.5 percent excluded women who had had previous episodes of either depression or PTSD—the women most potentially vulnerable. Even if women do not meet full criteria, up to 30% can have trauma symptoms (Soet, Brack, & Dilorio, 2003). Unfortunately, trauma after birth is by no means a rare problem.

What Makes an Experience Negative?

When researchers first started studying trauma related to birth, they consistently found that quality of birth experience had relatively little impact on women's mental health. These findings were in stark contrast to the stories women were telling themselves. One reason for this confusion, I believe, was that researchers were often seeking to define "good" and "bad" in terms of objective characteristics: length of labor, use of pain medications, medical interventions, and type of delivery. Indeed, the most typical way that researchers have considered the question of negative birth experiences is to compare women's reactions to cesarean vs. vaginal births, assuming that vaginal deliveries are usually positive, and cesareans are usually negative. Objective factors do have some influence but they cannot fully explain women's reactions to birth. Indeed, a woman's subjective experience of her care is far more predictive of her reaction.

Women's Subjective Experience of Events

According to Figley's (1986) conceptualization, events are troubling to the extent that they are "sudden, dangerous, and overwhelming." These characteristics have a great deal of relevance to birth.

- **Suddenness** occurs when an event strikes and there is not time to prepare, devise an escape plan, or prevent the event. This certainly occurs when women are in the hospital and in labor; change can happen in seconds, and there may be little time to react.
- **The dangerousness** of the situation is the second element. Many women perceive that labor is life-threatening for themselves or their babies. In terms of PTSD, it is the mother's perception that matters, not whether her perceptions are medically "true." The situation is similar to a crime victim who believes that she will be killed—even if the criminal had no intention of killing her. What she believes is much more relevant to her subsequent reaction than the medical facts associated with the event. Unfortunately, health care providers often unwittingly compound this reaction by saying something like, "if you had been out on the prairie, you would have died."
- The final element is the extent to which the situation is **overwhelming.** Some women describe being swept away by their birth experiences and the hospital routines. Being overwhelmed leads to a sense of helplessness and loss of control. The same can be true for her partner.

Sally's emergency cesarean had all three aspects that are likely to put women at risk for traumatic-stress reactions. Her baby was born within 15 minutes of when the cord prolapsed after having been in labor for 23 hours. (A prolapsed cord is potentially life-threatening complication that necessitates immediate cesarean delivery.) Her delivery was by cesarean section under general anesthesia.

> They had me on the bed, rear end in the air. My head was down between the headboard and the mattress. The nurse had to hold the baby off the cord. All I kept hearing was "OB emergency, OB emergency" over the loud speaker, while the nurse kept saying in my ear that the baby would be fine. Everything happened so quickly, I didn't have time to react.

Cheryl Beck, in her study of women who had traumatic deliveries, also found that perceived danger predicted negative reactions. She noted that birth trauma was likely to occur

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when the women perceived that they or their babies were in danger, and the birthing women themselves experienced "overwhelming fear, helplessness, loss of control or horror" (2004a, p. 28). Related to that is women's perceived level of care. If women felt cared for during their births, they were more likely to perceive them positively. In contrast, women in Beck's study described their care providers as cold, mechanical or uncaring, and that they felt degraded or raped after their experiences.

Women's sense of power and control can also influence their reactions. Women who felt like they had no control were more likely to react negatively. Perceived control can also explain why women can feel positively about an objectively difficult birth: if they felt that they had a say in what happened to them vs. that others made the decisions about their care (Kendall-Tackett, 2005).

Elizabeth's story illustrates this point. Her chart would, no doubt, indicate that her birth went well, with no complications. However, that was not her interpretation of events. And she was still troubled by her experience several years after it occurred. Her birth took place in a large, respected New York City hospital.

> I had 25 hours of labor. It was long and hard. I was in a city hospital. It was a dirty, unfriendly, and hostile environment. There was urine on the floor of the bathroom in the labor room. There were 100 babies born that day. I had to wait 8 hours to get into a hospital room post-delivery.... There were 10-15 women in the post-delivery room waiting for a hospital room, all moaning, with our beds being bumped into each other by the nursing staff. I was taking Demerol for the pain. I had a major episiotomy. I was overwhelmed by it all and in a lot of pain. I couldn't urinate. They kept catheterizing me. My fifth catheterization was really painful. I had lots of swelling and anxiety because I couldn't urinate. My wedding ring was stuck on my finger from my swelling. The night nurse said she'd had patients that had body swelling due to not urinating and their organs had "exploded." Therefore, she catheterized me again. They left the catheter in for an hour and a half. There was lots of pain. My bladder was empty but they wouldn't believe me. I went to sleep and woke up in a panic attack. I couldn't breathe and I couldn't understand what had happened.

Beck (2004a) noted how women in her sample were terrified by the hospital experience itself. These women trusted the hospital staff to provide safe care–trusting not only their lives, but the lives of their babies—and the doctors and nurses provided unsafe care. In summarizing these women's experiences, Beck (2004a) noted the following.

> Women who perceived that they had experienced traumatic births viewed the site of their labor and delivery as a battlefield. While engaged in battle, their protective layers were stripped away, leaving them exposed to the onslaught of birth trauma. Stripped from these women were their individuality, dignity, control, communication, caring, trust, and support and reassurance (p. 34).

A Tale of Two Births: One Woman's Story

In this section, I share one woman's story of her two births. Each birth was difficult, but for different reasons. Both of these stories have elements that I described above–fear of dying, overwhelming pain, experiences that overpowered her, and re-experiencing of events.

> When Peter was born, the birth itself was pain free. He was small, especially his head and shoulders, and it truly didn't hurt at all. I kept insisting I wasn't really in labor up until two minutes before he was born, when the doctor told me to lie down, shut up and push! But afterwards, he was born at 9:30, they told us he had Down syndrome at noon, and by 4 p.m., I was hemorrhaging so badly that I came within two minutes of death. I had to have an emergency D & C with no anesthesia (talk about PAIN!!) and a big blood transfusion.
>
> That night, they told us Peter needed immediate surgery and had to go to a hospital in another city. A very traumatic day, to say the least. And then they sent me home the next day with no mention at all that I might want to talk to somebody about any of this—the Down syndrome, the near-death experience, nothing. I can still call up those memories with crystal clarity. And whenever we hear about another couple, I have to re-process those feelings. Interestingly, most of them relate to the hemorrhaging and D & C, not to the Down syndrome "news." They're all tied up together. Maybe it's good to remind myself every so often of how precious life is.
>
> My third birth was excruciatingly painful—baby was 9 lbs 3 ounces, with severe shoulder dystocia—his head was delivered 20 minutes before his shoulders. I had some Stadol in the IV line right before transition, but that's all the pain relief I had. I thought I was going to die, and lost all perspective on the fact that I was having a baby. I just tried to live through each contraction.
>
> That night, after Alex was born (at 9 in the morning), I could not sleep at all because every time I tried to go to sleep, my brain would start re-running the tape of labor, and I would feel the pain and the fright and the fears of dying all over again. I stayed up all that night and the next day, and didn't sleep until I was home in my own bed.

In these stories, we see some classic symptoms of a posttraumatic response: fear of dying, re-experiencing the event, sleeplessness. She did eventually come to a place of peace over her experiences, but the memories of those two episodes of labor have remained vivid.

What Might We Expect in Ethnic-Minority Populations?

Research on this topic is relatively new. And as has been the case with other areas of women's health research, White middle-class women were the first to speak out on this issue. Researchers have not yet documented the experiences of ethnic-minority women and other populations that might be more adversely impacted by a typical American birth. However, clinicians working with a perinatal population can make some reasonable hypotheses based on clinical experience. Ethnic-minority women, particularly immigrant women who may not speak English, may find themselves even more overwhelmed by American hospitals than their White counterparts.

Health disparities between White and minority women are also obvious when it comes to birth. Ethnic-minority women have dramatically higher rates of both preterm birth and infant mortality—increasing the likelihood that their births are dangerous and high risk (Banks et al., 2005). In addition, women who are teens or low-income may also have late or no prenatal care and may be giving birth without preparation. What these clinical observations suggest is that what White women experience as dangerous or frightening can be even more so for women of color.

Summary

Childbirth is a very common event in the lives of women. Unfortunately, it can also severely impact women in ways that have them reeling for months and years after. And because there is generally a happy outcome associated with their experiences (i.e., a healthy baby), women may find that no one wants to talk with them about what happened. Birth can cause psychological trauma on its own, and it can trigger memories of previous traumatic events. In working with trauma survivors, or researching trauma in the lives of women, it's important to recognize this relatively common source.

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Pediatric Psychology Partnership for Abuse Prevention: An Exportable Model for Teaching Graduate Psychology Trainees to Assess for and Intervene in Intimate Partner Violence

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Intimate partner violence (IPV) is prevalent and takes a significant toll on the psychological and physical health functioning of women and their children (e.g., Golding, 1999; Kitzmann, Gaylord, Holt, & Kenny, 2003; Plichta, 2004). In 1999, the American Psychological Association adopted the Resolution on Male Violence Against Women (American Psychological Association, 1999), asserting, among other things, that psychologists play an important role in recognizing, intervening and preventing violence against women through research, practice and policy efforts. Moreover, the resolution urged enhanced training of psychologists to recognize and treat victims of violence. Excellent recommendations for educating trainees in assessing for/intervening in partner violence exist in the form of specialized IPV courses (e.g., Intimate Partner Abuse and Relationship Violence Working Group, 2001); however, graduate psychology programs are often unable to augment already full courses schedules with an additional specialized course or add specialty training tracks. If psychology hopes to prepare psychologists in the area of partner violence, training programs need exportable curricula that can be integrated within the existing program design. The Pediatric Psychology Partnership for Abuse Prevention (PPPAP) is a Graduate Psychology Education project, funded by the Health Services and Resources Administration since 2002, designed to enhance graduate education in recognizing and intervening in IPV using culturally sensitive methodologies. The curricular enhancements, which were integrated within the extant graduate program, provide guidelines on how psychology trainees can receive universal exposure to IPV-related issues and how subsets of trainees can receive in-depth training (for an overview of the project, see Weaver, Hughes, Friedman, Edwards, & Holmes, 2006). This article will describe the process of universal integration of IPV training within the clinical program and provide an in-depth examination of the case-based strategy used to educate graduate trainees in a team setting.


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Creating a Culture of Relevance

The field of clinical psychology is uniquely poised to address the health issue of IPV. Specifically, clinical psychologists are trained to conduct behavioral assessments, discuss sensitive topics and implement crisis-based interventions. Therefore, the first objective of the program was to make the topic of IPV assessment/intervention relevant to the clinical psychology faculty and clinical psychology trainees, regardless of specialty area, and to showcase work in this area as an extension of skills that are already being taught (or learned) within the graduate program. This strategy was designed to remove psychologist-identified barriers to screening/intervening in IPV, including the lack of training in this area and concerns over the sensitivity and potentially distressing content of IPV screening/intervening (Samuelson & Campbell, 2005).

In order to meet the first objective, the current core curriculum in clinical psychology (including psychopathology, clinical assessment, psychological interventions, ethics, and human diversity) was enhanced to include broad-based exposure to IPV. Standardized didactic modules that could be integrated into these core classes were developed. By teaching IPV across the core, all clinical psychology trainees receive multiple opportunities for exposure to IPV, taught by different faculty within different contexts. In this way, IPV is modeled as a universal topic, rather than a specialty area.

The clinical psychology faculty prepared for adding these integrated modules by attending a half-day faculty development lecture conducted by the project director, another faculty member with expertise on the effects of IPV on children, and an advocate from the local domestic violence community. The topics for the inservice included the epidemiology and sequelae of IPV, strategies for screening for IPV, and safety planning. Following the lecture, each faculty instructor of one of the core courses received a notebook with articles and recommendations for integrating a module on IPV into their course. For example, epidemiology and sequelae of IPV is taught in psychopathology, screening for IPV is taught in clinical assessment, safety planning for IPV is taught in clinical interventions, etc. Typically modules were designed to be 30–45 minutes in length. Additional assistance for developing the module was available through the project director if needed.

Enhanced Clinical Vertical Team

More in-depth training in IPV takes place in the context of an enhanced version of the standard clinical vertical team (CVT). Enhancements to the standard clinical team included modular presentations on IPV, a five week placement at a pediatric practicum site, and utilization of problem-based learning cases. These enhancements were integrated within the standard CVT, so that IPV-specific information was included along with other broad-based clinical case formulations, psychological assessment and interventions. This integration provided an even richer illustration of the clinical relevance of IPV.

The site chosen for clinical training was University Pediatrics at SSM Cardinal Glennon Children's Medical Center in St. Louis City, a medically underserved community. This ambulatory primary care setting serves as a site for training medical students and is the primary training site for the Pediatric Residency Program at the Saint Louis University School of Medicine. Each year, University Pediatrics serves an average of 6,000 patients, 80% of whom are African American. The clinic also serves Hispanic, Vietnamese, Bosnian, African and Chinese populations, among others. Most clients are from lower SES backgrounds; 80% are on Medicaid. Most are from inner city Saint Louis or the equally underserved North County. Finally, University Pediatrics serves a large percentage of single and adolescent mothers. Typical clinic presentations include poor nutrition, failure to thrive, prematurity, asthma and behavioral or school-related problems.

To bolster clinical integration in health care service, clinical psychology trainees accompany medical students and pediatric residents into clinic visits with female caregivers (who were unaccompanied by a male) to provide universal screening and safety planning for IPV. In order to further the integration of IPV as a healthcare issue, clinical psychology trainees also assessed for and provided information on behavioral health concerns that were parent/adult-focused (e.g., financial concerns, difficulties with discipline, their own eating habits, their cigarette smoking, parenting skills, and overall relationship conflicts) and child-related (e.g., children's eating and weight issues, academic difficulties, anger difficulties, sleep, mood, cigarette smoking) (Weaver et al., 2006). Therefore, clinical psychology trainees were fully integrated into the health care visits and the pediatric resident or medical student was present during the screening/safety planning and discussion of behavioral health issues in order to provide a multidisciplinary team approach. To prepare them for this practicum, trainees receive a broad range of experiences, including exposure to IPV within their clinical core, standard didactic readings on their CVT, and experiential learning using problem-based learning (PBL) cases.

Problem Based Learning: An Experiential Educational Modality

PBL was originally created for use in medical education as a self-directed, exploratory process; it has evolved into *hybrid* strategies that take advantage of the best practices of didactic, content driven teaching and self-directed, team learning. Problems or cases are developed that allow the learning community formed by the trainees to evaluate the knowledge they already have and to determine what additional information the team needs to solve the problem or process the case.

PBL has been shown to be effective at increasing students' problem-solving ability (Gijbels, Dochy, Van den Bossche, & Segers, 2005). By challenging students to generate solutions to problems that parallel those within a learning environment, students learn critical thinking skills (Hmelo-Silver, 2004). PBL is a particularly apt teaching strategy for graduate education in the area of IPV. These cases are intended to be realistic and engaging; thus, PBL can help prepare students for their own reactions to working with victims of IPV, while developing cognitive frameworks for problem-solving may facilitate quick thinking in later clinical situations.

Realistic, fictional cases form the backbone of PBL. The development of these cases was conducted within a multidisciplinary team consisting of three psychologists, a pediatrician, who also holds Master's degrees in public health and adult education, and an advocate from the domestic violence advocacy community. Each case was guided by a curriculum matrix, including categories reflecting the core clinical courses and accompanying learning issues (see Washington, Tysinger, Snell & Palmer, 2003 for more details on utilizing a curriculum matrix).

The case was presented to trainees in installments at a series of meetings over a period of 4–5 weeks. After reading each installment (typically no more than one page), trainees develop a list of "what they know" and a list of "need to know issues." This "list" of what needs to be learned is divided among the trainees, who then take responsibility for gathering the knowledge and reporting it back to the group. This process continues as new problems or additional facts in the case are provided to the team. Several outcomes usually occur. The team works as a unit to discover knowledge and apply that knowledge to the case or problem. In addition, individual students develop areas of expertise within the problem and serve as an expert to the team. The process is generative: each answer or report generates the need for additional knowledge and understanding. Finally a link develops between the evidence or facts needed to solve a problem and the skills needed to work with the client.

Case Example: Adolescent with a Toothache

The following example illustrates how a case study was presented in weekly installments to a team of psychological trainees. With the first installment, trainees received information on the fictitious client's chief complaint and its history. *Carin Sims, 14 yrs, presented at University Pediatrics unaccompanied as a walk-in complaining of a toothache. She explained that the tooth had been "killing her" for over a week and she was unable to chew on the affected side. She stated that she was feeling hot and appeared flushed. Carin arrived to the appointment as a walk-in, unaccompanied, and used the city bus for transportation.*

A week later in the next installment, trainees received information related to Carin's past medical, family, academic, and social history. Information was also provided related to her current medications. *Carin resides in a family of four, including her mother, father and 6-year-old brother, Tray, who has a developmental disability. Carin was born and resides in South, Saint Louis City. She stated that her parents argue often, mostly about money, since Mr. Sims has had difficulty maintaining steady employment, while Ms. Sims has two part-time jobs. Carin is in the 8th grade at Greater Saint Louis Middle School. Her grades are mostly Bs and Cs. This semester, she was suspended 3 days for fighting with a female peer. Carin reported that she has a boyfriend, Justin, and that they have been "going out" for one month. She has had boyfriends for the past couple of years. Her medications include Depo-Provera and Claritin. Carin's health behaviors included occasional drinking with Justin, occasional cigarette smoking, sexual activity with Justin, including vaginal and oral intercourse. Her first sexual experience was at 12 years. Carin reports no regular condom use because Justin objects, and she's "already getting the shot." Her last pelvic exam was conducted 2 years ago.*

The third installment included the assessment conducted within the pediatric office, laboratory test results, and further assessment of relationship history and family functioning. *Carin's current physical symptoms included tooth pain, general fatigue, low appetite, lower abdominal pain, vaginal itching, particularly around the time of her period, and a temperature of 100º F. Upon oral examination, her affected tooth appeared to have developed an abscess. A pelvic exam uncovered patchy red spots on the genitals, vagina, and cervix. A PAP smear and vaginal wet mount were conducted. Results from laboratory tests confirmed that Carin was positive for Chlamydia and Trichomoniasis. Further assessment of Carin's relationship history revealed that her current boyfriend, Justin is 18 yrs old and very popular. The couple spends most of their time with his friends, and she spends little time with her old friends because Justin is jealous of other guys. They have had a couple of fights. She reports that one time he twisted her arm behind her back, "but he was probably just joking around." Carin described her parents as stressed and busy. She stated that both her parents frequently drink alcohol, but her father drinks more heavily than her mother. She said that her mom and dad fight often. The police have been called twice because of the noise. Her mother has had some bruises on her face after some arguments. During the fights, Carin takes her brother into her room. She then calls Justin on the cell phone and he comes to pick her up.*

The fourth installment focused on the course of medical treatment and the psychosocial intervention. *Carin was immediately referred to a dentist for drainage of the abscess. Azithromycin and Metronidazole were prescribed for the Chlamydia and Trichomoniasis. Psychosocial intervention included didactic education about the STD transmission and prevention strategies. Ways to successfully engage these strategies were also discussed. Barriers to using these strategies were explored including concerns that Justin would "think she was fooling around; Justin is the best thing that I have going in my life." When Carin's psychological functioning was assessed, she stated that she was basically happy, but has periods of sadness, especially when things are rough at home. Carin said that Justin is one of the few things that can make her feel better. Since Carin was "at risk" in her relationship and in her family, safety planning was discussed. Carin's support options were broadened to include an aunt, a school counselor, and a 24-hour crisis counseling center with a dedicated line for adolescents. Risky situations for re-exposure to the STDs were discussed. Carin stated that she was "willing to consider using condoms, if it was ok with Justin." Carin was scheduled for a return appointment to the adolescent clinic in 3 months.*

The final installment detailed the outcome of these interventions. *Initially, Carin missed her follow-up appointment. After rescheduling, Carin and her mother presented at the appointed time. In a private conversation with the healthcare provider, Carin said Justin blamed the STDs on her, accused her*

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of "sleeping around" and slapped her. She called the crisis line and found them "kind of helpful." Carin allowed her STDs to be discussed with her mother at this visit. In addition, an assessment of family violence was conducted with Ms. Sims. Ms. Sims said that her husband does get "out of hand" at times. Safety planning was discussed and a referral given for a local sliding scale counseling center. Counseling for Carin also introduced. Carin was rescreened for STDs, and the results came back negative. She stated that she still hopes to stay with Justin. Another rescreening appointment was scheduled for 3 months, and Carin was encouraged to bring her mother.

Summary

Pediatric Psychology Partnership for Abuse Prevention was developed to provide an exportable model for universal training of clinical psychology trainees in IPV screening and intervention. Rather than developing specialized courses or tracks, this model is based on enhancements to the existing clinical core courses and clinical vertical team. For further information on exportable IPV training materials, please see http://www.pediatricpsychologypartnership.com.

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Acknowledgments

This work was supported in part by funds from the Division of Medicine and Dentistry (DMD), Bureau of Health Professions (BHPr), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS) under USPHS 4 D40 HP0051-03, Pediatric-Psychology Partnership for Abuse Prevention, Terri L. Weaver, PhD, principal investigator. The information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsement be inferred by the DMD, BHPR, DHHS, or the U.S. government.

Journal of Psychological Trauma Accepted Into PsychInfo

Haworth Press, Inc., is pleased to note that the Journal of Psychological Trauma has just been officially accepted into PsychInfo of the American Psychological Association. We are now working with the bibliographic staff at APA to see if we can have the legacy content (going back to Volume I, #1) included retroactively.

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Project Ujima: Providing Comprehensive Care to Youth Violence Victims

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Introduction

Interpersonal violence represents a significant public health problem among youth in the United States (Koop & Lundberg, 1992). The prevalence of youth violence is perhaps best illustrated by the large numbers of children and adolescents presenting to hospital Emergency Departments (EDs) each year with assault-related injuries (Centers for Disease Control, 2006). Re-injury rates among assault victims are high (44%), and hospital staff often treat the same patients repeatedly for subsequent violent injuries (Sims et al., 1989). Following treatment of their acute medical concerns, most youth are sent back into their communities without receiving attention to their psychosocial needs. Given evidence that being a victim of violence is a significant predictor of becoming a victim or perpetrator of violence in the future (Thomas, Leite & Duncan, 1998), assaulted youth presenting to the ED represent an important at-risk population for secondary prevention.

Project Ujima is an example of a unique secondary prevention program providing hospital- and community-based intervention services to violently injured youth and their families. Ujima is a Swahili word meaning "collective work and responsibility" or "working together to make things right." The main goals of the program are to: (1) reduce the physical and psychosocial consequences of interpersonal assault and (2) reduce rates of violent re-injury (Marcelle & Melzer-Lange, 2001). In this article, we provide a brief overview of the Ujima program, and our collaborative approach for managing program participants' mental health needs.

Background of Program Development

In 1994, ED staff at Children's Hospital of Wisconsin (CHW) treated over 180 children between the ages of 5 and 18 years for firearm injuries. Many assault victims required medical follow-up yet few returned for appropriate follow-up care (Melzer-Lange, Lye, & Calhoun, 1998). Contemporaneously, experts were recommending a comprehensive approach to the care of assault victims in medical settings (Walsh-Kelly & Strait, 1998). Through the efforts of a multidisciplinary group organized by the trauma and injury prevention nurse at CHW, planning for Project Ujima ensued. Initial financial support came as in-kind from various partner agencies. Subsequent funding was provided by the Children's Hospital Foundation, Targeted-Issues funding from Emergency Medical Services for Children, the Allstate Foundation, and the U.S. Department of Justice. Project Ujima's current key partner agencies include CHW, the Medical College of Wisconsin, Children's Service Society of Milwaukee, and the Marquette University Psychology Clinic.

Program Description

Project Ujima serves over 240 youth victims in Milwaukee County annually. Historically, nearly 70% of participating youth are African American, and nearly 70% are male. The majority are referred from the CHW ED/Trauma Center with injuries secondary to firearms or physical assault. Additional referral sources include community and school health clinics, the court system, and the child welfare system. Families may participate in the program for up to two years. Services are provided in the family's home or community at no cost and include medical follow-up and medical referrals for treating victims' physical wounds; mental health treatment to address the effects of violence and the trauma response; legal advocacy; and assistance in obtaining Crime Victim Compensation.

Mental Health Services

The psychological consequences of interpersonal victimization among youth are well-established~~.~~–Including elevated rates of depression, posttraumatic stress disorder (PTSD), substance use, and delinquency (Kilpatrick, Saunders, & Smith, 2003). Left untreated, these mental health problems tend to follow a chronic course resulting in long-term impairments in functioning. Thus, the provision of mental health services to the families participating in Project Ujima represents a critical aspect of the program. Mental health services are delivered using a phase-oriented intervention protocol including stabilization, assessment, and intervention.

Stabilization. This first phase of intervention begins at the initial home visit approximately two weeks post-injury. During this visit, families meet with a treatment team (e.g., project liaison, nurse, master's level therapist) to learn about youth and family programming and to receive medical follow-up attention. Research suggests that the provision of formal mental health services in the acute aftermath of ~~a~~ trauma, before the individual has had time to process the event, can lead to worse psychosocial outcomes (van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002). Therefore, Project Ujima therapists limit their immediate interventions to "psychological first aid" (Litz, Gray, Bryant, & Adler, 2002). Examples of first aid interventions commonly delivered during the initial visit include safety planning, psychoeducation, and information on coping.

The family and therapist collaborate to evaluate current safety, and ~~to~~ determine situations with high risk for future victimization (e.g., frequent contact with the perpetrator at school or in the neighborhood). After potentially dangerous situations are identified, the therapist assists the victim in developing an appropriate action plan. The therapist orally reviews the action plan and provides visual reminders

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(e.g., reminder card to place in purse/wallet) as a cue to implement the plan at the appropriate time.

Project Ujima therapists also provide brief psychoeducation on common psychological responses to traumatic injury. For youth and parents who are experiencing acute distress, coping strategies (using diaphragmatic breathing or another anxiety management technique) are discussed. Parental support is important to the recovery of a child following a traumatic experience (Garbarino, Dubrow, Kostelny, & Pardo, 1992). Therefore, we normalize common parental responses to youth trauma (e.g., guilt, fear) and emphasize the importance of support during recovery from the injury (for both the parent and youth).

The therapist's next steps depend primarily on the information gathered during initial assessment. If a youth or parent reports trauma symptoms during the initial interview, we schedule another home visit about four weeks following the assault to assess post-injury adaptation. If trauma symptoms persist at this subsequent visit, the youth or parent is referred for more comprehensive assessment and intervention services. If the youth or parent does not report trauma-related distress, but is experiencing other psychosocial concerns (e.g., depression, behavior problems), referral for a more thorough psychological assessment can occur immediately.

Assessment. Youth and parents referred for more comprehensive psychological evaluation complete a standard assessment battery. The assessment battery includes self- and parent-report rating scales, a semi-structured diagnostic interview, and brief measures of family and academic functioning. This battery was designed to cover the broad range of psychiatric symptoms and contextual concerns commonly experienced by youth and parents exposed to community violence (McCart, Davies, Phelps, Heuermann, & Melzer-Lange, 2006; Phelps et al., 2006). Once the initial assessment is complete, the therapist assists the family in choosing an appropriate intervention.

Intervention. Intervention services for families may include any or all of the following: individual therapy, school and court advocacy, or community referral. Youth who are displaying aggressive or delinquent behavior problems (representing a majority of the Project Ujima participants) are invited to participate in a multi-component intervention blending aspects of Behavioral Parent Training (BPT) and Cognitive-Behavioral Therapy (CBT). We combine BPT and CBT into one intervention package because studies have shown this multi-modal approach to be more effective than either intervention alone (Kazdin, Siegel, & Bass, 1992). The BPT component teaches parents about the causes of youth aggression and reviews principles of effective behavior management. The CBT component is modeled after the Positive Adolescent Choices Training (PACT; Yung & Hammond, 1995) program and includes modules on problem-solving skills training, anger management, and education about violence. We recently evaluated the effectiveness of our BPT + CBT intervention in a randomized controlled trial. Results are promising and reveal reduced aggressive behavior problems and improved parenting among the families who received the intervention (McCart, Davies, Phelps, & Melzer-Lange, 2007).

For youth or parents who report continued trauma symptoms four or more weeks following the assault, formal trauma-focused treatment is initiated. Our trauma intervention protocol mirrors other empirically supported treatments for PTSD (e.g., Deblinger, Lippmann, & Steer, 1996; Foa, Hearst-Ikeda, Perry, 1995), and includes psychoeducation, relaxation training, cognitive restructuring, and exposure-based elements. Therapy may also address preexisting concerns that can impact recovery from the youth's assault, including parent-child communication difficulties, emotional dysregulation, and symptoms associated with mood disorders. Youth experiencing serious psychiatric problems such as psychosis, substance abuse, or suicidal ideation are typically referred to another provider in the community for more intensive psychiatric services.

Case Example: DM

A 15 year old boy was transported to the ED/TC by paramedics for a gunshot wound to the upper thigh. While DM was being evaluated for his injuries, hospital social services and a Project Ujima liaison were available to support him, his mother, and his two siblings. Project Ujima services were described to DM and his mother, and both consented to participate in the program. On discharge, plans were set for a home visit by the Project Ujima team. DM's mother did not report any mental health needs during the home visit. However, DM was described as having a history of aggressive behavior problems that had become more severe following his assault. He also reported experiencing some PTSD symptoms, including hyperarousal and intrusive thoughts about the shooting. DM began participating in a home-based CBT intervention involving anger-management and conflict resolution training. His mother also participated in BPT. DM's aggressive behavior reduced in severity after about 6 consecutive weeks of home-based treatment. However, his PTSD symptoms persisted. To address these symptoms, DM learned various anxiety-management techniques. He also participated in imaginal exposure intervention during which he was instructed to describe the traumatic event in as much detail as possible, focusing on the environmental stimuli, behavior, cognitions, and emotions he experienced and observed during the traumatic event. Repeated imaginal exposure facilitates fear extinction, which refers to the gradual decrease in PTSD symptoms over time. DM showed a good response to these interventions; he reported a significant reduction in PTSD symptoms after about 5 weeks of trauma-focused treatment. During the course of treatment, the Project Ujima liaison and nurse also worked to assure DM's attendance at his medical and physical therapy appointments, to help the family complete the Crime Victim Compensation application, and to promote the re-entry of DM into his high school classes. This collaborative approach, with an emphasis on psychological support, permitted DM and his family to cope with his victimization and to return to his normal school and social activities.

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VOICES FROM THE CLASSROOM

Trauma in Diverse Populations: Student Research Dissertations

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Student dissertations are usually the culmination of years of hard work, fervor, and diligent research. The dissertation process provides students with the opportunity to read and review the literature on topics of interest and identify areas requiring further investigation. The completed dissertation contributes to the field of psychology by providing thoughtful analysis and insights that add to the database of previous research. During this time, student researchers become experts on their specific topics, and set the stage for future research directions. Many students seek to bridge the gap in professional literature by analyzing diverse populations and the impacts of various types of trauma on those populations.

The following dissertation descriptions are just a few examples of student research highlighting both cultural factors and trauma. These students are in various stages of the dissertation process: two are preparing to defend their proposals; one is in the data collection stage; and one student has successfully defended her dissertation. Research topics include: community violence in preschoolers; culturally diverse adolescents entering foster care; the role of education in developing resiliency in at-risk adolescents; and the impact of war on the self-concept of Nicaraguan women.

The Development and Study of Treatment Intervention for Parents and Preschoolers Living in a Violent Community

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Research suggests that impoverished children living in violent communities are traumatized by continual exposure to shootings, stabbings, fights, arrests, domestic violence, and violent media. To date, the majority of research on the effects of exposure to community violence has focused on

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school-age children and adolescents, while few studies have examined the prevalence of community violence exposure in underserved populations of very young children or how such exposure correlates to behavior and development. Initial findings indicate that preschoolers are being exposed to disturbingly high rates of community violence similar to that of their school-age and adolescent counterparts, and a need for interventions with young children exposed to such violence has been identified.

This study focuses on understanding preschoolers' perceptions of violence in their community and identifying age-appropriate strategies for talking with young children about violence. The outcome of this study will be a manual for teachers and parents that will outline psycho-educational activities for both parents and children and provide information and coping strategies to those living in violent communities, including: identifying violent acts commonly witnessed by community members; understanding the impact of cumulative exposure to community violence; learning about coping strategies, warning signs, discipline and developmental norms; and identifying treatment resources. Additionally, the manual will include models for building collaborative relationships with community members and tailoring interventions to specific cultural and/or community needs based on community responses

Assisting Culturally Diverse Adolescent Girls Make a Successful Transition Into Foster Care: A Psychoeducational Group Intervention for Survivors of Trauma

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Many adolescents entering foster care for the first time are impacted by the various types of traumatic experiences they have encountered, including types of childhood abuse and subsequent removal from their homes. According to the California Department of Social Services (2003), in the course of a year, more than 700,000 children enter California's child welfare system. In Alameda County, there were 4,725 children in foster care by the end of 2001. In terms of ethnicity, approximately 75% of initial entries into California's Alameda County foster care system were children and adolescents of color. Adolescents are particularly prone to experiencing difficulties around their racial identity.

The purpose of the study is to design, implement, and evaluate a 10-week psycho-educational group intervention for 12–14-year-old adolescent girls in foster care in Alameda County. This early intervention is intended to help survivors of trauma successfully adjust to the foster care system.

Trauma And Resiliency: The Role of Education in the Lives of Academically Resilient At-Risk Youth

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Many at-risk youth experience trauma in their childhood and very few graduate from college. The disparity between the college attrition rates of at-risk youth and their non-at-risk youth counterparts is staggering. Similarly, the difference between the life of an at-risk youth who reaches higher education vs. an at-risk youth who becomes entangled in a life of crime underscores the vast potential impact of each path, not only on the life of the youth but on our communities and ultimately society as a whole. Despite the far-reaching benefits of supporting the educational pursuits of at-risk youth, there are not enough programs to meet the need. Likewise, there is a gap in our understanding of the interplay between trauma and *academic* resiliency, particularly among students of color, immigrants and those of low SES.

The proposed study seeks to conduct an in-depth exploration of the role of education in the lives of academically resilient college students who experienced trauma in their childhood. The study will attempt to identify the dominant themes among college students through a semi-structured interview process. Data collected from the interviews will be analyzed utilizing content analysis. Participants of the proposed study will consist of college students and recent college graduates of both genders and multiple ethnicities. Participants will be recruited from a San Francisco Bay Area not-for-profit organization that awards financial assistance, mentorship, and other resources to at-risk students, all of whom have experienced some form of trauma.

In addition to helping to fill a gap in the existing literature, the purpose of the proposed study is to gain an understanding of the role of education in the lives of students who have experienced trauma and to learn about possible common themes that support or constrain the development of at-risk students' *academic resiliency.*

The Impact of Revolutionary War on the Self-Concept and Social Role Formation of Nicaraguan Women

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John F. Kennedy University, Defended December 2006
(Graduated June 2007
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Most research on the experience of war has focused on Post Traumatic Stress Disorder and its impact on war veterans. The literature addressing the experience of war and its influences on those civilians directly affected is limited. What is less studied is how these effects are experienced and, in some ways, internalized, specifically by those who have lived through traumatic wartime experiences as civilians.

This study explored how the experience of revolutionary war has informed the self-concept and social role formation of Nicaraguan women through the use of qualitative (phenomenological) methodology. This research identified common themes in the experiences of these women. Ten women from various areas, ages, occupations, and social statuses who have lived through the period of revolutionary war in Nicaragua participated in this study. Information was obtained utilizing a three-part format: an initial screening, an hour-long interview, and a short debriefing. The results of these interviews were analyzed to reveal shared themes in the experiences of these women. It is hoped that this research may benefit the field of psychology by broadening the narrow lens through which Latina women are often viewed. Furthermore, this research sheds light on treatment considerations for those in the caring professions working with women who have been forever altered by this type of experience.

The Education and Training Committee

Anne DePrince, PhD

New Training Program List

Anne DePrince, PhD

The Education and Training Committee is pleased to announce the launch of a new list of undergraduate and graduate psychology programs with either program emphasis and/or faculty expertise in trauma psychology, available on the Division 56 Resource Page. This initial list was compiled based on a series of web searches, but we know that there are many more training sites out there. We look forward to incorporating additional sites and faculty into this resource. To help us expand this list, please take a moment to visit the list, which you can access at http://www.apatraumadivision.org/resources.php, and send corrections or updates to Anne DePrince at adeprinc@du.edu.

We hope that this list will provide useful information to students seeking training in trauma psychology. For example, the list indicates whether graduate programs are APA accredited or provide training for undergraduates and/or masters only. When available on the web, we have included examples of associated faculty's interests.

The Education and Training Committee will be working on additional electronic resources related to training and curriculum issues. If you have ideas or requests for resources, please email Anne at adeprinc@du.edu.

Fellows Committee

Charles R. Figley, PhD, Chair

The 2007 APA Fellows in the Division of Trauma Psychology

Charles R. Figley, PhD

We now have 123 Fellows within APA's newest division, our Division 56. This is the first year the Division has its own Fellows, 122 of whom are Founding Fellows. You might be wondering: How our new Division processed so many Fellow applications so quickly? Good question. I would like to explain how we came to honor these esteemed psychologists.

Each year the APA (specifically the APA Fellows Committee) considers the applications for APA Fellows status within APA. Bestowing APA Fellows status on a member is a high honor. Information about Fellows Status within APA can be found at our Division website at http://www.apa.org/membership/fellows.html where the application process is outlined in detail.

Current Fellows are APA Members who are already Fellows in other divisions, and may also become Fellows in another division without approval from the APA Fellows Committee. Once an APA Member has been approved by the Fellows Committee, Board of Directors and Council of Representatives for Fellow status in one division, they do not need further approval from APA to become a Fellow in additional divisions. It is the responsibility of each division to determine eligibility of Current Fellows and to notify APA of their election.

More than a year ago it was decided by the Executive Council of the Division that all members of Division 56 at its founding as an APA Division should be approved as a Fellow of the Division and should from that day forward be considered a Founding Fellow of the APA Trauma Psychology Division. The decision became official in September. In addition the only member who was approved as a new Fellow of the division is A. Steven Frankel. A current list of our Fellows can be found at http://mailer.fsu.edu/~cfigley/FellowsofDiv56_6Sept07.htm. If you know of any of these Fellows, please send them a quick email to express your congratulations.

Finally, if you yourself are interested becoming a new Fellow of APA, or if you are already an APA fellow, or you would like a colleague to be considered for either distinction please visit http://mailer.fsu.edu/~cfigley/Div56apa07fellows.htm. Submissions are accepted on line only, and must conform to the APA Fellows process.

International Committee Report

Elizabeth Carll, PhD, Chair

Elizabeth Carll, PhD

The mission of the International Committee is to insure that international issues are represented in Division business and policies and to foster international collaboration and communication concerning trauma related issues.

To begin to foster connections and build bridges with other Divisions, the International Committee organized an international focused program for the 2007 APA Annual Convention on psychological trauma with presentations covering large-scale to individual intervention. The 2-hour symposium, Psychological Trauma: Best Practices, Innovations, and International Perspectives had many attendees and resulted in lively discussion following the presentations. The symposium, cosponsored by Divisions 55, 42, 56, 1, 12, and 18, included 4 international participants from England, Spain, and The Netherlands as well as participants from the U.S.

The program was organized and chaired by Elizabeth Carll, PhD. Participants discussed a wide variety of trauma related issues, with Elaine LeVine, PhD, discussing the integration of psychotherapy and pharmacotherapy in the Treatment of PTSD and the development of a biopsychosocial model of care. Jim Alvarez, PhD, spoke about the trauma of kidnap and discussed interventions for victims and their families. Fernando Chacón, PhD, and Marísa Luisa Vecina, PhD, discussed best practices and interventions following the 2004 Madrid terrorist attack. Rachel M. MacNair, PhD, spoke about the trauma of killing and the impact on perpetrators such as military service personnel. Cheryl Gore-Felton, PhD presented on the importance of pairing trauma treatment with HIV prevention to reduce sexual risk. Eric Vermetten MD, PhD, discussed the development of an online Web platform for supporting survivors of the tsunami. (See photo.)

The symposium presenters were also contributors to the newly published (August 2007) book *Trauma Psychology: Issues in Violence, Disaster, Health, and Illness, Two Volumes* (Volume 1: Violence and Disaster; Volume 2: Health and Illness) edited by Elizabeth Carll, PhD, and published by Greenwood Praeger. Those interested in the above areas as well as the diversity of topics in trauma psychology will find detailed information in the volumes.

The International Committee is developing a Resource Listing of International Trauma Training Programs. This will serve as a resource for members and other visitors who are interested in international trauma issues. If you know of international training programs in trauma, please contact Elizabeth Carll at ecarll@optonline.net or 631-754-2424 for the possibility of including it in the resource listing.

Participants in the APA convention symposium, Psychological Trauma: Best Practices, Innovations, and International Perspectives. Front row, left to right: Fernando Chacón, Marísa Luisa Vecina, Elizabeth Carll, Rachel MacNair, Cheryl Gore-Felton, Elaine LeVine. Back row, left to right: Jim Alvarez and Eric Vermetten.

Lenore Walker

Media & Public Information Committee

Lenore Walker, Chair

The Media & Public Information Committee is beginning a project to collect current or developing podcasts of 1–3 minutes on the various areas of trauma that psychologists work on. Anyone who has already developed a podcast or is thinking about doing so, and is willing to share, please contact Lenore Walker at walkerle@nova.edu or Rachel Needle at needlerb@nova.edu.

Associate Editor Needed

The Trauma Psychology Newsletter is interested in identifying an Associate Editor. Please see the position description listed on page 32 of this newsletter. If you are interested in contributing, please send a letter of interest and experience, along with a copy of your CV, to Newsletter Editor, Topher Collier (DrTopherCollier@aol.com).

Practice Committee

Christine A. Courtois, PhD, Chair

Christine A. Courtois

The Practice Committee is in the midst of organizing or helping to organize a variety of projects.

The most significant at this point is the formation of a Division 56 Task Force to monitor the *DSM-V* revision. The American Psychiatric Association has recently announced the 27 members of the Task Force that will oversee the development of *DSM-V*. Although an Anxiety Disorders Work Group was announced, chaired by Katherine Phillips, MD, no specific mention was made of whether the group will include attention to Posttraumatic Stress Disorders or the Dissociative Disorders. Division 56 President Judie Alpert has named Dan Brown, PhD, of the Practice Committee to chair this Task Force with the preliminary charge to: monitor the activities of the *DSM-V* TF on issues related to trauma disorders; provide input to the *DSM-V TF*; request serving as a liaison to the *DSM* group; encourage and monitor activity by the APA Practice Directorate and provide them input related to the *DSM* and trauma with regard to their contact with the *DSM* group; and work with Division SIGS involved trauma disorders as a way of having more communication and input. At the Executive Committee meeting, it was also determined that an important goal would be for the Task Force to establish contacts with other organizations with a trauma-related purpose or agenda to form an organizational coalition. At the follow-up meeting with those Practice Committee members in attendance at APA: Chris Courtois, Laura Brown, Mary Gail Frawley-O'Dea, Sylvia Marotta (later joined by Division President Judie Alpert and Nancy Baker of Division 35), it was decided that action within our APA regarding the *DSM* revision is also necessary. Planning is currently underway to decide how best to inform various APA committees and task forces, as well as the Council of Representatives, about issues of concern with the DSM revision.

Other ongoing activities include:

- Participation in the planning group for the two day conference, Summit on Interpersonal Violence, Abuse, and Trauma: New Actions, co-chaired by Division 56 President-elect, Bob Geffner, PhD and Division 35 President-elect, Jackie White. The conference will be held on February 28 and 29 in Bethesda, MD, the same weekend as the Division Executive Committee meeting. Practice Committee member Sylvia Marotta is serving on the planning committee.

- Development of an article in the APA Monitor on trauma, posttraumatic reactions and effects, and posttraumatic disorders and treatment. Sylvia Marotta is heading up this effort and has been in contact with Rhea Pearlman, head of APA communications.

- Chris Courtois attended the CAPP and Practice Directorates Liaison Consultation meeting held during the convention. This meeting was geared to the discussion of important issues in the practice community. A wide variety of practice issues including reimbursement rates, Medicare update, parity update, disaster response activities, were discussed.

- The Practice Committee is working in conjunction with Education and Training Committee to suggest the development of a line of APA videotapes on trauma and trauma treatment.

- Chris Courtois, PhD, was awarded Division 56 The Distinguished Contribution to the Practice of Trauma Psychology at the Division's Business Meeting.

Special Interest Groups (SIG) Committee

Desnee Hall, PhD

Desnee Hall, PhD

Division 56 approved the formation of Special Interest Groups (SIGs) at APA's Annual Convention in August. Seventeen Special Interest Groups have been proposed to date and will become operational once a minimum of 10 members of the Division have indicated their interest and willingness to participate. Non-member participants may also join a SIG but cannot serve on SIG committees and do not count toward the 10-member minimum. The currently proposed SIGs are:

- Military/Emergency Trauma
- Refugee Issues and Torture
- Disaster Related Trauma and Response
- Human Trafficking
- Child and Adolescent Trauma
- Adult Survivors of Abuse
- Sexual Victimization
- Intimate Partner Violence
- Medical Trauma, Illness, and Rehabilitation
- Intergenerational Transmission of Trauma
- Trauma from Discrimination, Marginalization, and Oppression
- Health Effects of Trauma

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Committee Reports

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- Complex Trauma
- Dissociation
- Israel and the Middle East
- Neuroscience of Trauma
- Trauma to Postcolonial Peoples

Of these, three already meet membership criteria and are forming committees to head up each SIG. These are the Dissociation SIG, chaired by Harold Siegel (e-mail linkmets@aol.com for information about the Dissociation SIG), and the Child and Adolescent Trauma and Trauma to Postcolonial Peoples SIGs, whose committees are currently in formation (contact Desnee Hall, e-mail DesneeHallPhD@aol.com for information about the Child and Adolescent Trauma group and Lisa Thomas, e-mail lrthomas@u.washington.edu for information about the Postcolonial Trauma group). Several additional SIGs are very close to meeting membership criteria.

The Division approved rules and procedures that define how a SIG is formed, maintained, and, if necessary, dissolved, and established a Special Interest Group Coordinator to oversee these processes. The SIG Coordinator, currently Desnee Hall, is a member of the Executive Council of the Division and serves a three-year term. Although the rules and procedures for creating SIGs are detailed, they are intended to foster a "bottoms up" approach to structuring the division, allowing members to define their own goals and interests and to work together in creative and innovative ways to further the work of trauma psychology.

SIGs will formulate their own mission statements and may develop their own listservs, newsletters, websites, and conferences. They may also meet annually at the APA convention. The groups will be created and dissolved as particular interests increase or decrease in importance to the membership of the Division and are meant to flexibly respond to and keep pace with growing sophistication in the theory and practice of trauma psychology and with increased social, political, and environmental demands on those who provide trauma support. They are intended both to enhance the theoretical and clinical skills of their members and to provide a professional community to support the very difficult work that people working in the area of trauma perform.

Although membership in the Division is not a prerequisite to joining a Special Interest Group, the Executive Council hopes that interest in the SIGs will stimulate membership in the Division, as so many psychology professionals are learning to cope with the traumatic influences in their own and their patients' lives. For information about joining the Division, contact Sandra Mattar, email smattar@jfku.edu. For information about joining a SIG or proposing a new SIG, contact Desnee Hall, e-mail DesneeHallPhD@aol.com.

Hypocrisy and Perversion in the Catholic Church

Andrea Celenza, PhD

Book Review: *Perversion of Power: Sexual Abuse in the Catholic Church* by Mary Gail Frawley O'Dea Nashville, Vanderbilt Univ Press.

Andrea Celenza, PhD

There is no more hypocritical and perverse exploitation of power than the sexual abuse crisis in the Catholic Church. Americans have been deluged with report after report of priests' sexual molestation of minors and the immoral cover-up by their bishops that only enabled more abuse. The cover illustration of Mary Gail Frawley O'Dea's book on the subject captures this darkly perverse scandal and pulls at our heart strings—the silhouette of an innocent but admiring altar boy looking up at a trusted priest . . . it's actually hard to look at the cover.

Few writers on this subject, however, have tried to comprehensively amass the data about this crisis as well as explain it at a sufficiently sophisticated level. Mary Gail Frawley O'Dea has done both and more in *Perversion of Power: Sexual Abuse in the Catholic Church.* Frawley O'Dea sets for herself a high standard—to go beyond the reporting of idealized perpetrators and their crimes against innocent children. She delves deeper, tells the story from both victim's and perpetrator's perspectives, does so through a contemporary and a historical lens, and analyzes (describes as well as explains) the scandalous cover-up. To fully address these issues, she also weaves her perceptive knowledge of theology, psychoanalysis, and passionate spirituality throughout.

Frawley O'Dea concentrates on the years between 1950 and 2002 when about 4,300 priests abused over 11,000 victims. A later study brings the number of accused priests to over 4,800 (John Jay College of Criminal Justice, 2004). This accounts for about 4.75% of the priesthood and it must always be remembered that these are only the cases that have been reported. Frawley O'Dea presents us with the fact that 2/3 of the bishops overseeing these accused priests allowed them to continue working. Many participated in the ensuing cover-up, especially those empowered with the authority to stop it, including bishops, cardinals, and popes. She does not hesitate to let us know where she stands on this by stating throughout the book, "The cover-up *is* the scandal" (p. 10). By now, the Catholic Church has paid over $1 billion in sexual abuse lawsuits and, more importantly, has lost credibility worldwide.

As if the sexual molestation were not trauma enough, O'Dea reports abominable damage that was wrought on the victims as the priests called them sinful and told them that God hated them for their actions, filling them with shame and self-loathing as well as demolishing their faith. Of course, these perpetrators sought out fatherless children and particularly vulnerable but trusting and needy victims. As is true for most trauma victims molested at a developmentally fragile age, their sexual molestation became a “central thematic strand of their lives” (p. 17) warping their identity and poisoning their faith.

One of the distinguishing characteristics of this book is the way in which Frawley O’Dea integrates her vast descriptions of numerous aspects of the crisis with her incisive knowledge of theology, especially the underpinnings of classical Catholicism. She reminds us that the organized church is an imperfect instantiation of this theology and not coincident with it. Though probably not her intention, this book could return your faith as she offers important distinctions between the historical institution’s interpretations of Catholic theology and iconography from the theologically more pure understanding of Jesus’ life. She defrocks, as it were, the *valorization of suffering*, for example. She informs us that this is not in the Bible nor was it lived by Jesus. Likewise, the emphasis on the *crucifixion* (as part of Catholic symbology over other aspects of Jesus’ life, ministry and resurrection) and *masochistic asceticism* are not part of Christ’s teachings. Some of the damage infused in the psyches of the victims used masochistic asceticism as a value; many were told to accept their suffering as Christ accepted his.

Frawley O’Dea finds the roots of sexual abuse and the cover-up in classical interpretations of Catholic theology, especially sadomasochistic power relations, the valorization of suffering, sadistic interpretations of the Crucifix, as well as deeply problematic avenues for embodied and gendered self-expression within the church hierarchy. She contends that “Catholic theological renderings . . . are often stultifying to human psychological and spiritual growth and even can be unethical.” These include dualistic views of the body, misogynistic views of women, the inability of priests to fulfill stereotypical masculine gender norms, the oppression of lust, the straitjacketing of condoned sex into marital sex, the imposition of celibacy, and the Church’s relationship to homosexuality. She adds to this her broad psychoanalytic knowledge of trauma and sexual abuse to explain the motives of the perpetrators. For example, she posits a temporary identification with domineering superiors as part of the perpetrator’s motivation, implicating the problematic church hierarchy in the overall scandal as well.

In this book, Frawley O’Dea discusses Christian theology and the ways in which spiritual teachings have developed over the centuries to culminate in the Catholic Church as we know it today. Pre- and post- Vatican II are not the only junctures; the first and second centuries already saw misinterpretations of Christ’s teachings and Frawley O’Dea catalogues these in a theme-driven mode that underlies her deconstruction—a religion that became hierarchically organized by relationships of domination and submission. She makes the sexual abuse crisis explainable across a broad spectrum of issues, but never falls into a language that might excuse the priests or (especially) the bishops who were responsible for them. So, in large measure, this is also a book of accountability, a sorely needed correction that is satisfying in and of itself.

An example of Frawley O’Dea’s broad and sophisticated treatment of her themes is her chapter on celibacy. She informs the reader of its historical beginnings, rooted in economic concerns that then became theologically justified. It was the Lateran Council in 1139 that deemed celibacy mandatory for all priests. This mandate insured that popes, bishops, and priests would have no offspring who could inherit their father’s holy offices or require financial support. Both outcomes were problematic eventualities of married priests prior to the Council with all the difficulties associated with nepotism as well (e.g., incompetent heirs). Thus, celibacy solved a sociopolitical and economic problem for the church and the valorization of celibacy followed in order to institutionalize it. Coupling with ascetic masochism, the degradation of women, and the church’s intolerance of sexual pleasure for its own sake, celibacy was already well positioned to become an overarching and entrenched value. Quoting Richard Sipe, a critic of obligatory celibacy, “Celibacy offers . . . a graced opportunity to live in the image of Christ . . . The truly celibate priest [is seen as] transcendent, even mystic” (Sipe, 2003, p. 90). To be fair, Frawley O’Dea includes positive outcomes of celibacy as well. Not only does the mandate of celibacy insure that the Church retains its property; it also preserves the continuity of parishes, monasteries and abbeys.

In her continuing discussion of celibacy, Frawley O’Dea brings us to the present and reviews the ethnographic studies from within the church to describe the ways in which celibacy is actually lived now. Probably the most extensive study spanning a forty year period was performed by Richard Sipe (2003, p. 89). His conclusions reflect that approximately 50% of priests are living out a life of celibacy at any given time. Others are sexually active with women, adult men, or engage in other sexual activities such as masturbation, pornography, or exhibitionism. Though Frawley O’Dea is always careful to acknowledge members of the clergy who do not engage in hypocritical, unethical, or outright abusive activities (and mercifully, there are high percentages of these), she documents the fact that 9 American bishops who led diocese have resigned since 1990 amid allegations of sexual misconduct. In the wake of these allegations, there is no lack of the usual denials, externalization of blame, and in general an “institutional lack of empathy” for the victims of the misconduct or abuse.

It may surprise the reader to learn that even nuns, cloistered in convents and clothed from head to toe, are not safe from exploitation. Frawley O’Dea does not rely on hearsay or anecdote; here too, she cites a comprehensive study of more than 1,100 nuns from 123 different orders and found 6% having had sexual liaisons with priests or vowed religious men. Twenty-nine were impregnated by priests in one community and, shockingly, priests brought pregnant nuns to abortion clinics to dispose of the fetuses. Yet another disturbing fact includes the rape of some religious women in Africa (France, 2004). Though the Vatican claimed that the rape of nuns by priests was confined to Africa (given that nuns could be considered safe sexual partners for priests and prelates fearful of contracting AIDS), Frawley O’Dea cites

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studies reflecting this behavior in 23 countries, including the United States (Filteau, 2003; Smith, 2003).

Whether the abuse involves adult men or women, adolescents, or children, the fundamental concern described throughout the book is that the relationship with a priest is one that is structured around a power imbalance. Even if the victim is an adult and not a member of the priest's parish, the priest is "a representative of the Divine . . . [and] unconsciously draws erotically tinged yearnings for intimate, even sexual, communion with the Divine" (p. 96). In this way, Frawley O'Dea demonstrates her facile marriage of psychoanalytic insight with passionate spirituality. She goes on to reveal other unconscious mechanisms operating at deeper levels, for example, including the paradigm of fatherhood embedded in the role of the paternal priest—the living icon of the Law ritualized in confession and the meting out of penance.

In addition to the sexual molestation of male minors, some priests adopted their victims as foster children in order to provide the child with a needed paternal figure and home. This was but a thin disguise for the priest's opportunistic move to experience a kind of sublimated fatherhood in his relationship with his victim and, of course, a well designed cover for the abuse. Frawley O'Dea cites authors who have found that a large percentage of priests are drawn to the priesthood in search of their own psychic fathers (Hoge, 2002; Celenza, 2004) and Frawley O'Dea suggests that the victimization of minors is an attempt to experience a father-son bond from the dominant position. For others, it is an attempt to relate to a psychic equal given the immature developmental level of some priests.

In one of the finest examples of Frawley O'Dea's facility with psychoanalytic insights and language, she describes her wish for the Church's future stances on both celibacy and homosexuality: "Perhaps instead it would be productive, humane, and spiritually sound for Catholic officials to assume relational views of both celibacy and homosexuality. Here, each sexual orientation could be evaluated according to the relational context in which it is expressed. Celibacy and homosexuality, along with heterosexuality, could be deemed ethical, procreative, and spiritually meaningful to the extent that the psychological and spiritual growth of individuals and those in relationship with them were enhanced by the union. Similarly, any enacted sexual orientation could be considered destructive if it impeded an individual's or couple's relationship with self, other, and God" (p. 111). Despite her obvious disillusionment with the institutionalized Church, she cannot help but expose her hope for the Church in positive terms.

Frawley O'Dea has meticulously reviewed an enormous amount of data from a great variety of sources. Beyond a comprehensive review of books, book chapters, and journal articles in her professional literature search, she references the media (including newspaper articles, magazines articles and Television news reports), as well as judicial reports and Vatican documents, all of which reported on the crisis in the last five years. Finally, she applies her expert psychoanalytic knowledge of trauma and development to offer a scholarship that cannot be matched and that has culminated in a definitive expose of the scandal and its origins.

This book will be interesting to a wider audience than those curious about the facts behind the sexual abuse crisis and its perverse cover-up. This book should be read by all disaffected Catholics who have had difficulty with the ways in which the institutionalized church has interpreted Christ's teachings as well as those readers who want the real and full story behind the sexual abuse crisis and the scandalous cover-up in its wake.

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Teaching Moments on Post-Traumatic Stress Disorder in Families

Linda J. Rubin, PhD
Texas Woman's University

Book Review: Sherman M. D., & Sherman, D. M. (2005). *Finding my way: A teen's guide to living with a parent who has experienced trauma*. Woodbury, MN: Seed of Hope Books.

Linda J. Rubin, PhD

In an effort to fill in a gap in the self-help literature on how adolescents can learn to understand and to cope with a parent who is suffering with post-traumatic stress disorder (PTSD), Sherman and Sherman (2005) have developed an accurate, clear, easy to read workbook titled, *Finding my way: A teen's guide to living with a parent who has experienced trauma*. The goals of this book are to help teenagers to normalize the experience of living in a family where PTSD has an active presence, to explain the features of traumatic stress and the treatment options available for the traumatized parent, to identify healthy coping strategies for teenagers, and to offer resources for additional learning opportunities.

This workbook is written in a straightforward style with short, uncomplicated chapters. In the first chapter, the potentially confusing term, post-traumatic stress disorder, is broken down into each of its component parts and is explained in simple, easy to understand language. Each chapter includes several questions directed to readers and is designed to stimulate the readers' personal connections to the material presented. For example, in the second chapter devoted to the symptoms of trauma, readers are asked questions about how their parent expresses traumatic symptoms: "How does your parent re-live the trauma?" (p. 14); "What does your parent avoid?" (p. 15); and "Which of the following words describe your parent's anger or temper?" (p. 19). For each of these types of questions as well as other activities (e.g., make lists of pros and cons, map your network of close friends), readers are asked about how their parent's post-traumatic experience affects them. Space is provided to write answers in the workbook.

Throughout the book, concrete and relevant case examples are included to illustrate the features, treatments, and coping strategies described. In the case examples, a range of names from different cultural groups is used, indicating an appropriate awareness of and sensitivity to some issues of diversity. This same awareness of and sensitivity to religious diversity is missing. In the numerous instances when some reference was made to religion (e.g., talk to a minister, pray at church), a clear bias is present in favor of Christian faiths. Obviously, not all people of faith have clergy referred to as ministers; religious leaders may be tied to Judaism, Buddhism, Islam, Hinduism, or other religions, and be called rabbis, monks, priests, imam, spiritual leader, or have other meaningful titles. Also, not all houses of worship are churches; people of faith may worship in temples, mosques, synagogues, or other meaningful locations. Of course, I would think it important to make this workbook meaningful to adolescents who are atheist or agnostic and have no religious affiliation at all. My hope is that this book would be inclusive of teenagers from any religious group and of teenagers from no religious group.

The authors have posited many positive messages that can be useful in the development of good mental health for teenagers and their families in general and in many instances are not specifically limited to families struggling with PTSD. Plainly written examples normalizing human experience can be valuable information for all young people, including identifying anger as a normal human emotion, explaining that a wide range of feelings about family is a common experience, and describing family struggles as typical. The task of normalizing the specific experience of PTSD in families focused on the idea that all members of a family unit will be impacted when a parent experiences traumatic stress. Additional examples of crucial messages for good mental health development in teens that are clearly articulated and written directly to the adolescent are: (1) You have control over your thoughts, feelings, and behaviors; (2) You have the power to choose how to respond in your family; (3) Asking a trusted adult for help when you need it is a good idea and takes courage; (4) Every person's experience is different; (5) PTSD (or any mental health disorder) is not an excuse for unkind behavior; and (6) Take all comments about suicide seriously. These are well-articulated and important messages to communicate to youths.

I suggest that two additional teaching moments may have been overlooked. First, in keeping with APA guidelines regarding writing in gender neutral (i.e., non-sexist) language, it seems that the term "man-made" (p. 8) needs to be written as "human-made," a particularly important message in teaching young people to avoid the use of language that minimizes others or renders girls/women invisible. Second, a question was asked in the chapter on how to talk with friends about dealing with PTSD in the family: "How did their [your friends'] reactions *make you feel*?" (p. 89; italics added). The language *make you feel* suggests that the teens' feelings are caused by the friends' reactions. Consistent with one of the basic messages of this book is the idea that all feelings are okay and that individuals are responsible for their own feelings; that is, others do not *make us feel* anything. We feel whatever we feel and that is okay. Given that the purpose of this book is to teach some basic tenets of good, adaptive mental health, it seems important to take each of these additional issues as teaching moments.

Available help and recommended coping strategies for both the parent with PTSD and teenagers are described in basic ways that are not threatening or frightening. Treatment options identified for the parent with PTSD include psychotherapy, medication, support groups, family involvement, and perhaps the need for temporary hospitalization. Seeking out these forms of treatment is described as courageous and the role of the adolescent is integrated into the explanation, giving young readers the clear message that they can make a difference and have a positive impact on the family. A range of options for self-care for the teens with specific examples was provided: Gather information (e.g., surf the internet, read a book about PTSD), healthy distractions (e.g., watch a movie, hang out with friends), express your feelings/find support (e.g., keep a journal, talk to a trusted friend), relax (e.g., take deep breaths, go on a walk), do physical activities (e.g., take a bike ride, lift weights), and help others (an open-ended question is presented without specific examples on this item).

Several appendices (though these sections are not referred to as such) are also included: List of Feelings, Glossary, Frequently Asked Questions (FAQ), a Note to Professionals, and a Note to Parents. The list of feelings is a valuable tool and could be made more valuable by creating a more comprehensive listing of feelings. The glossary has accurate content and is easy to read in a manner consistent with the rest of the book. The FAQ section represents a summary of the highlights of the book, including questions such as: "What does my parent do in counseling? What should I tell my friends about my family?" (p. 110); "What should I do if I feel in danger? What should I do if I start to feel depressed" (p. 111); and "What should I do if I have gone through a traumatic experience myself?" (p. 112). The Note to Professionals offers a very brief overview of the book's content and several ideas on how the book might be adapted to work with clients. This Note to Professionals incorporates two references embedded in the text, without a full citation

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Teaching Moments...

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of those references anywhere in the book. Additional statements about prevalence rates and the "burgeoning literature on the physical and psychological benefits of journaling…." (p. 124) have no references, which are needed in a communication to other professionals. The Note to Parents serves as a brief introduction to the book and makes an important point about how avoidance of feelings in teens can result in an increased sense of shame; this is an important point that deserves further attention in the book.

A brief listing of resources in the final chapter includes websites, phone numbers, and self-help books on anxiety disorders in general and post-traumatic stress disorder in particular, depression and suicide, substance abuse, and mental illness in general. This book is exclusively available for purchase at www.seedsofhopebooks.com.

A Window into the Soul: Trauma Work in Paraguay and Brasil

George F. Rhoades, Jr., PhD
Chair, Diversity and Multicultural Concerns Subcommittee

George F. Rhoades, Jr., PhD

The Soul can be described as "The central or integral part; the vital core" (The American Heritage College Dictionary, 2004, p.1323) of an individual. A window into the vital core of a person is often provided by a better understanding of the person's cultural heritage and practice. The experience of trauma knows no bounds on gender, race, nationality, or economic standing. This newsletter's "Window to the Soul" is a personal sharing of recent trauma work down in the South American Countries of Paraguay and Brazil (spelled Brasil in country).

It was my privilege to travel to Paraguay (Sept. 9–16, 2007) at the request of the country's First Lady and under my work with GAiN (humanitarian group). My trip into Paraguay involved basically two days of journey, with a three-hour delay in Ciudad del Este (City of the East) due to the fires that had literally enveloped the airport in the capitol city, Asuncion, in smoke. The First Lady sent a car to pick me up and the resulting four hour journey across country was beautiful, seeing the countryside and small towns on the way. The trainings were broken into two groups, a day and a-half for Government Workers (Justice, Police, Firemen, Psychiatrists, Psychologists, Social Workers, Nurses and the First Lady's Office), and Pastors and church workers. We worked on the effects of trauma with children and adolescents, anger management, the power of forgiveness, Psychological First Aid, and my Three Step Model for the Treatment of Trauma and Dissociation. Sandra Baita and Paula Moreno (Trauma Therapists) of Argentina came over and presented two days of workshops on Child Abuse, involving understanding, diagnostic and treatment considerations. They presented to a combined group of around 200 persons (125 government workers and 94 pastor/church workers).

The trainings were well attended and well received. There was considerable interaction on how to deal with the traumas of the country, including a tragedy about two or three years ago that involved a supermarket being consumed by fire, the doors being locked on the people. Over 400 people died and at least 200 children were orphaned as a result. The trial was continuing during the time of our stay, and the store's owner and son were out on bail, something that was causing considerable resentment among the population. The current fires were a constant reminder of the tragedy and contributed to allergies and pre-existing lung conditions. The high rate of child abuse and suicide (especially among teens) were other areas of concern.

It was exciting to conduct one TV interview on what we were doing in Paraguay and a radio show on teens and suicide. The trip to an orphanage though was most memorable to me. The orphanage is a private Christian one that is run by a woman that treats each orphan as her own child. When I visited with representatives of GAiN, there were 185 children there, the most recent a 17-day-old child (William) that was "dropped off" that day. I encountered a room full of children excited to get an animal balloon. When I tried to hand the first balloon to a child, I was told that the little girl couldn't speak, and it was obvious that one of her hands didn't function properly. The next balloon I tried to hand to a small boy, only to be told that he was blind. I encountered rooms that were small, holding up to 34 children per room, most often four to a bed, with mattresses on the floor also. Very clean facilities with a lot of smiles. I asked three questions, "How are you able to continue this work?" "How many staff do you have?" and "How long do your children stay in the orphanage?" The responses were "By God's Grace" (I learned later that the food that day was all they had left. A truck with supplies coming to them had broken down before it arrived that day), The workers are older orphans that help take care of the younger orphans and in response to the last question, the Director asked me a question. She asked, "How long do you allow your children to live at home?" I am happy to note that GAiN is providing meals for the orphanage through at least January.

A consultation with the only hospital devoted to children and adolescents was very meaningful. I lectured to hospital staff on the "Effects of Trauma on Children and Adolescents" and then demonstrated the sand tray as a technique to facilitate the evaluation and treatment of children. We were able to leave the inflatable sand tray and toys behind for the staff to continue to use. My time then with the psychiatrist, eight psychologists and one social worker in separate case consultations was very gratifying. The discussion of a child impacted by child abuse and a different case of an 11-year-old suicide were very moving. The hospital would be very open to internships for graduate students in psychology.

All three of us (Sandra, Paula and I) also had many opportunities to interact with workshop participants in a personal way, often helping to provide insight into very painful situations.

My travel into Brasil (9/16–9/20) was quite intense as I had to travel through Sao Paulo, an airport that had a tragic airplane crash a short while ago. The delay was over three hours, with much confusion as to gates and when the flight would take off. My arrival into Brasilia was delightful as Marcello Faria (ISSTD colleague) was waiting for me with a big smile and a Tee shirt that said “Dr. George Rhoades in Brazil, www.isst-d.org.” I have two shirts with this on it; my family has big smiles when I wear them at home. Marcello was an excellent host and a good advocate of understanding trauma and dissociation in Brazil. His dissertation regarding multiple personality disorder is the first known for that country. Marcello arranged for me to do an hour interview on trauma and dissociation with a media group that has up to 20 million viewers. I was also privileged to do an hour lecture on “The Effects of Trauma on Children and Adolescents” that will also be repeatedly shown to this audience.

The lecture at the Catholic University, Universidade Catolica de Brasilia, was well received and resulted in much interaction on trauma and dissociation. The University and much of Brazil psychological community is psychoanalytically based and as such much of this material was new to them. Making the connections with psychoanalysis and then expanding to look at the broader field of trauma and dissociation was well received. The psychology professors are hungry for more information on this whole field.

My old sinus problems acted up in both countries, but I was truly blessed on this trip. Thanks for letting me share about another journey. I want to thank everyone for all the prayers and supportive thoughts, especially Sandra, Paula, and Marcello.

If cross-cultural work interests you, please consider being part of Division 56’s subcommittee on Diversity and Cross-Cultural Concerns. If you would like to have more information please contact either George Rhoades at rhoades@pdchawaii.com or Priscilla Dass-Brailsford at pdbrails@lesley.edu.

Reference

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Distinguished Dissertation Award for Exemplary Dissertation Research in Trauma Psychology

Presented Saturday, August 18th, 2007, during the Division 56 Award Ceremony at the 115th APA convention in San Francisco

The Roles of Betrayal and Culture in Trauma Sequelae: A Japanese Sample

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Advisor: Jennifer J. Freyd, PhD

Betrayal trauma theory (Freyd, 1996) presents a theoretically grounded proposition that abuse perpetrated by a close other, epitomized by child abuse, is particularly detrimental to psychological health and memory function compared with abuse by a non-close perpetrator and non-interpersonal traumatic experiences. Betrayal may exacerbate the impact of trauma because of the conflict arising between the adaptiveness of maintaining attachment to the close other and otherwise functional responses to mistreatment (i.e., withdrawal or confrontation). This betrayal trauma effect had been found in the West but this study is the first known to the author to investigate the effect in a country with measurably different cultural values. Japan is a country that is in need of more child abuse research, where public opinion downplays its existence while anthropological reviews maintain that abuse of children is widespread and little empirical evidence exists from which conclusive information can be drawn.

In this study, 79 Japanese undergraduates were surveyed about potentially distressing experiences, current psychological functioning, and endorsement of traditional interdependence-based values such as interpersonal harmony and loss of face. Abuse perpetrated by close others before age 18 was reported by close to half of the students and significantly predicted greater psychological distress above and beyond distress related to any other interpersonal and non-interpersonal trauma experiences. In addition, memory disruption was more likely for abuse perpetrated by close others than for other non-interpersonal traumas, while the distribution of memory disruption for abuse by perpetrators who were identified as not close did not differ from that for non-interpersonal traumas. Endorsement of traditional interdependence-based cultural values did not moderate the betrayal effect on psychological symptoms or memory disruption.

These findings offer partial support for betrayal trauma theory as a cross-cultural model for predicting trauma outcomes and provide evidence of widespread abuse and associated psychological harm in Japan, which should inform prevention and intervention efforts.

Carolyn Allard completed this dissertation research under the direction of her advisor, Jennifer Freyd, in Freyd’s lab (see http://dynamic.uoregon.edu/) at the University of Oregon. Dr. Allard is now working with the Research Service of the VA in San Diego.

Presidential Voice

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"dying." I am referring to people passing as physically healthy when they are physically ill. Other psychoanalysts have written about passing. For example, see Sue Grand's (2000) perceptive writing about the therapist needing to pass as something other than she is. However, I could find nothing written by therapists on the topic of passing as physically healthy when one is ill. This is surprising as the passing I am describing seems to be relatively common.

At the outset I want to make clear that I do not have a physical illness. My interest in illness was stimulated by my late husband's experience with a rare neurodegenerative disease for which there is no known cure. I have learned about illness from living alongside his horrific disease for 12 years. In addition I have treated many well-spouses of the physically ill as well as some people with physical illness. In what follows, I make use of these experiences. Also, I make use of different types of illness narratives. Some are written in the third person and are fictional stories such as Eric-Emmanuel Schmitt's *Oscar and the Lady in Pink*. Others are first-person nonfictional narratives (e.g., Lang, Bauby, and Murphy).

In the present paper, I consider reasons why people choose to pass as physically healthy when they are physically ill. In the second part of the paper, I briefly consider how the ill person's family or significant other may pass as well. Toward the end of the paper, I consider the paradox that results from passing. Passing enables the person with a physical illness to keep his well self alive with others. By passing, the ill person is treated and seen as healthy or, at least, not sick. Also, he has some power as a "passer." To some extent, the ill person who has little or no control over his illness can at least control how he is seen. However, while passing enables him to feel alive, at the same time, passing results in his feeling dead, disconnected, detached, and inauthentic. When one is passing, relationships are dishonest. This is the paradox: While the falseness keeps him alive, it simultaneously makes him feel dead.

One more point: It should be clear that there are many illnesses. With some, one gets better while that is not the case with others. There are long-term illnesses and short-term illnesses. And there are illnesses that cause more or less physical pain. There are even illnesses which are in the "get better" category, and the person, despite categorization, does not get well. There are invisible illnesses and highly visible ones. Some begin as visible. Others only become visible over time. And so on. I speak to people passing in all of these categories.

Physically Ill People Passing As Healthy

Passing is not necessarily something which is done consistently. A physically ill person may go in and out of passing in any one day. He may go to work and pass as healthy at the office. He may lunch with a friend who "knows." When he returns to the office after lunch, he may again pass as healthy. There may even be people at work who know that he is physically ill and who talk to him about his illness during the work day. At the end of the day, at his doctor's appointment, for example, he presents as one with a physical illness. The masquerade oscillates.

The invisibility of some illnesses enables physically ill people to pass as healthy. At different stages of their illness, they may pass more or less. Even those who look sick and cannot hide illness by means of wigs or prosthesis may pass.

Mary provides an example. This high-powered attorney who is a partner in a large law firm has nonhodkins lymphoma. While she has no symptoms, she has painless swollen nodes that are diagnostic. As the disease progresses, more nodes appear and they reveal in such places as bone marrow. If untreated, death will result.

Originally it was believed to be an aggressive cancer and the treatment was heavy duty chemotherapy. She lost her hair, vomited profusely, and could not walk. She thought she was dying.

Recovery from chemotherapy was slow and lasted four months. When well, she was determined to never be helpless and sick again. She did more than pass. She became the epitome of apparent health. While never before athletic, she became a tri-athlete and the recipient of numerous trophies and applause. Only a few friends and family members knew of her bravery and of her ordeal.

Over time, she got better and needed less frequent cat scans. She believed she was cured.

Then, her internist discovered an enlarged spleen. Still, she was asymptomatic and did not experience fevers or fatigue. While she had struggled to pass earlier, this time she could easily pass. She was treated with a number of non FDA-approved drugs, and once every year, would have four rounds of maintenance treatment. The treatments resulted in her feeling sick and weak. Nevertheless, she was still able to pass.

Mary is single. She is a lawyer. She chooses to pass because she wants to meet a partner and knows that potential partners would not be interested in her if they knew about her illness. Also, she is sure her clients would leave and that there would be no new referrals if people knew. She is convinced that some friends and colleagues would shun her as well. Cancer phobia abounds even today, she told me.

While she hates the lying, hiding, and faking that is a part of her life as a "passer," she feels and is treated as a well person. She knows herself as a well person. Even when she feels sick, she knows herself as a well person. She is not ready to take on an identity as ill, and, so far, she does not have to.

Why Do People Choose to Pass?

Illness has consequence. Sometimes people choose to pass for as long as they can because they do not want to lose jobs, incomes, referrals, or clients.

Another consequence of physical illness is dismissal. The physically ill may be eliminated from, for example, social circles, invitations, referral lists and inheritance. They may no longer be seen as people with whom you can argue, depend on, or treat as equal. The list of topics which cannot be discussed with the physically ill may grow.

When Gordon's illness became known, people began to treat him differently. As soon as he left to go to the bathroom when out for dinner with friends, invariably friends would ask Gordon's wife how Gordon was doing. She would encourage them to ask him. They never would. In time, she learned to say to Gordon, in front of his friends, that his friends wanted to know how he was doing.

People, even those who are psychologically sophisticated and extremely well-intentioned, seem to have trouble talking about illness to the person with a disease.

Ten-year-old Oscar said (Schmitt, 2003, p. 104) "My illness is part of me. They don't have to act differently because I'm sick. Or can they only love an Oscar who's healthy?" Later Oscar tells the hospital volunteer: "They're afraid of me. They don't dare talk to me. And the less they dare, the more I feel life a monster. Why do I scare them so? Am I that ugly? Do I stink? Have I grown into an idiot without knowing it?" And Mamie-Rose explains: "They're not afraid of you Oscar. They're afraid of your illness."

In *The Diving Bell and The Butterfly* (1997), Jean-Domonique Bauby, who had "Locked- in Syndrome," a condition in which a patient is aware and awake but cannot move or communicate due to paralysis of nearly all voluntary muscles in the body, provides an extreme example of dismissal. He writes:

> At the Café de Flore, one of those base camps of Parisian snobbery that sends up rumors like flight of carrier pigeons, some close friends of mine overheard a conversation at the next table. The gossipers were as greedy as vultures that have just discovered a disemboweled antelope. "Did you know that Bauby is now a total vegetable?" said one. "Yes, I heard. A complete vegetable," came the reply. The word "vegetable" must have tasted sweet on the know-it-all's tongue, for it came up several times between mouthfuls of Welsh rarebit. The tone of voice left no doubt that henceforth I belonged to the vegetable stall and not to the human race. (p. 83)

There is consequence to having a serious illness, even with one's doctor. In their medical reports, for example, doctors dismiss the physically ill patient. The patient, no longer a person, becomes a heart or a lung or some other disease. The central character in the medical narrative is the illness and the experience of the patient is often silenced.

Sometimes illness is acceptable only when it is overcome. When there can be no promise of cure or assumption of a happy, fairy- tale ending, sometimes even medical doctors desert. They, too, may demand cure and refuse to bear witness to the final reality. Jane Brody quoted a letter in the *New York Times* (August 10, 2004) which was written to the doctor of the deceased by his spouse. I quote from it here:

> As you know, my wife was diagnosed with lung cancer in 1997 and was treated successfully by you for almost seven years. During that time, she developed a relationship of confidence with you which, given her many unhappy past experiences with doctors, was both encouraging and surprising.
>
> And yet, at the end, to her (and my) profound disappointment, you failed her. When you realized that you could do no more to reverse her progressive disease and that death had become inevitable, you abandoned her. You evaded her telephone calls; you waited 10 days before informing her of the April 2004 CAT scan results; you pulled away. The empathy you displayed was replaced by what she experienced as indifference.

After describing her husband and his interest and abilities, Groch, in the *New York Times* (July 6, 2004, p. F5), writes:

> Most of all, Bill never understood why all these nice doctors didn't have a few minutes to talk to him.

Gordon saw many doctors. He reported that, after he was diagnosed with an incurable disease, no one seemed to want to take him on as a patient, even though he took his medication as directed, kept appointments, and was pleasant.

Even ten year old Oscar knew that doctors are uneasy about illness. Oscar tells his doctor (p. 111):

> "Stop looking so guilty. It's not your fault that you're forced to give bad news to people, diseases with Latin names, and recuperation that won't happen. You should relax. Loosen up. You're not the one who orders nature around. You're just the repairman."

Hospitals may also desert. One woman told of how a prominent hospital specializing in cancer does not receive patients for triage purposes. In emergencies, patients are told to call 911 or to report to a local hospital.

Sometimes people pass because others demand that they do.

In addition to passing as healthy when physically ill, they may pass as less burdened than they, in fact, are.

People may say what they think others want to hear.

In response to a question about his health, Lang (2004, p. 127), who was suffering from Crohn's Disease records in his illness memoir:

> "It was hard at first, but after awhile you get used to it. It's not so bad anymore." He smiled at me, and nodded. "I'm sure that's what you tell people Jim, but I know that's not really true" I was momentarily taken aback at his response, but then recollected that he had spent the last year or two caring for his dying wife. "You're right," I said. "But that's what I tell people."

Those in the ill person's world may drive the passing. A surgeon's nurse demands that a woman wear a prosthesis following surgery for breast cancer. When questioned, the nurse reveals the reason she advocates for prosthesis: to elevate the spirits of people in the doctor's office (Rimmon-Kenan, 2002).

Illness bears similarity to the trauma of physical abuse. Both involve assault on the body. Both involve betrayal. While the betrayer of physical abuse is usually a parent, the person with a physical illness may feel betrayed by a higher power, a parent, or by oneself. Often with physical abuse there is powerlessness, inescapability, and disruption. Illness leads to these as well. The abused child may be told to pretend the abuse did not happen. The person with a wounded body is similarly told to wear wigs or other disguises and to feign wellness.

There may be a demand that the person with a physical illness outwit his illness by spirit, courage, and never-ending energy. Stories of people with illness are bursting with heroic coping accounts. There is little tolerance for sissy-behavior in this terrifying roller-coaster ride of sickness. Those watching the weakening carnival call on the infirm to display acts of bravery and gallantry. Perhaps the ill demand this response themselves. To not comply could result in more loss and failure.

There are many examples of lives of illness faced with pluck and daring. Walter rode his mechanical wheelchair from New York City to Washington, DC. in his effort to raise money for his affliction, ALS. At the onset of disease, Meryl, who had

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nonhodgkins lymphoma retired from the practice of law but not from vigorous living. She directed her energies toward learning about and influencing the science and politics of her disease. She testified on the hill about and raised money for research on her disease. Tour de France winner and cancer survivor Lance Armstrong, who became a cancer activist, provides another example.

Even Oscar had to die wise. Before he died, he wrote to God (Schmitt, 2003, p. 115):

> I tried to explain to my parents that life is quite a gift. At first you overestimate it, this gift: you think you've received eternal life. Then you underestimate it, you think it stinks, it's too short, you're almost ready to throw it away. Finally, you realize that it wasn't a gift at all, just a loan. Then you try to deserve it.

When we hear these stories, we applaud. Wonderment often follows. Are these daring folk responding to a cultural imperative? Is this their way of staying in life and maintaining control? There are benefits to this courage. There may be costs as well. What will happen when the disease overwhelms and they can no longer engage in these acts of heroism and confrontation?

In addition to the demand for confrontation and activism, there is another social role for the sick person and this, in contrast, involves submission. These the two roles, heroism and submission, co-exist.

Several papers on sickness as a social role (e.g., Talcott Parsons, 1958) indicate that a new responsibility replaces obligations attached to all former roles. The new responsibility is to get well, and submissiveness is the suitable part that must be performed. An anthropologist who developed a tumor of the spinal chord that gradually progressed to quadriplegia, wrote a narrative of his paralysis experience. He writes (Murphy, 1990, p. 20):

> As with all social roles, a person can succeed or fail at sickness. A key rule for being a successful sick person is: Don't complain! The person who smiles and jokes while in obvious physical misery is honored by all. Doctors and nurses are especially appreciative of this kind of patient, for he usually follows orders and seldom files malpractice suits. Hospital visitors also value cheeriness, and the sick person soon finds that he is expected to amuse them, and thus relieve their guilt at being well.

Sometimes people choose to pass because they can. Their illness is invisible and passing allows them to live longer as a seemingly healthy person and to be related to as such. Also, it may be too hard to stay with the illness. One may need to escape from illness, and passing allows this.

Illness is the process of coming to realize that one does not know oneself. The physically ill person may feel that he is a stranger to himself, and is not connected to his former self. When there is illness, one holds two irreconcilable representations of self: a more or less intact self and a more or less marred self. There is a discontinuity in identity leading some to talk about who they were and no longer are.

Murphy (1990, p. 19) an anthropology professor at Columbia University who developed a tumor of the spinal cord which resulted in quadriplegia, writes: "I was not simply confronting an unpleasant two or three weeks in the hospital, but a new way of life, a career of being sick." Later he writes (Murphy, p. 85):

> I had an increasing apprehension that I had lost much more than the full use of my legs. I had lost a part of myself. It was not just that people acted differently toward me, which they did, but rather that I felt differently toward myself. I had changed in my own mind, in my self-image, and in the basic conditions of my existence.

When ill, there is talk of body parts as if they are separate from themselves. It is as if, in that moment, they are looking at some part of themselves as belonging in the after while they are in the before. The lived past and the ongoing present are different. They feel as if they have lost part of themselves or, perhaps, their whole selves. Linearity appears to be gone. There is only polarization, disruption, and break. They return to the past by passing.

Even when one can no longer pass with others, the physically ill may choose to pass to himself. He can do so by daydreaming or dreaming about being his former healthy self. As an example: a man with a Lew Gehrig's Disease spent about 15 minutes every morning imagining that he was in a healthy body. The image enabled a reprieve from the harsh reality of wheel chairs, catheters, medication, aides, doctor's appointments, prisms and so on. The fantasies served as a bridge from the healthy known to the harsh reality of illness.

Jack and Jill: Passing and the Significant Other

Jack and Jill went up the hill to fetch a pail of water.
Jack fell down and broke his crown
And Jill came tumbling after.

This children's rhyme is relevant here. It points out that the falling of one has consequence for the other.

The experimental treatment given to 62-year-old Sam led to a one-year remission. Sam had prostate cancer which had metastasized to his lungs and bones. While his wife, sons, and sister knew about his illness and the gloomy prognosis, he did not want others to know. He wanted to continue to work and to lead a full life. He wanted to be treated as a healthy person. Thus, he chose to pass. Even after his remission, when he looked visibly ill and the cancer had spread to the bones in his upper body causing his upper frame to bend over, he opted to pass. Inquiries into his health were many given his devastating outer shell. However, he had a cover story and he smoothed away the voices of concern by declaring that he had spinal disc problems.

While he was a prosperous business man and did not need to work for financial reasons, he wanted to work. His choice to pass burdened his wife, sons, and sister as he asked them to maintain his cover with concerned friends and other family members. While they yearned for the support from friends and family, it is not available to those who pass or to their families who know. It is not simply the physically ill person who deals with the impact of passing. His partner or others who are privy to information about the illness may have to pass in order to keep the secret. They may hide their burdens and pass as one who does not live with a physically ill partner.

There are many ways that the partners of the physically ill pass. I name two here. First, they may have to be partners to the secrecy and deception as indicated above.

Second, they may pass by minimizing. They may hide their burdens and pass as someone whose burdens are much less than they are. They may do so to protect their spouse. They may even do so as a doomed-to-failure effort to protect themselves.

Joyce, the mother of three children under age 6, was 39 when her husband developed ALS. As she was determined to have her children lead as normal a life as possible, she picked up many responsibilities related to her husband's care rather than having aides and nurses intruding. Not surprisingly, she was exhausted and overwhelmed. She did not want to burden anyone, including her husband, with her concerns. She chose, instead, to pass to him and to others as one who could easily handle this monstrous burden. She was able to pass as some one who was in charge and unburdened. However, there was consequence. As she put it: "I lost the WE of me and I lost the ME of me."

There are some loving families who become even closer with illness such as what seemed to be the case with the families of Christopher Reeves and Elizabeth Edwards. In fact, there are many examples of families bravely and together facing the difficulties of illness and death. However, there are other families who engage in what, at first glance, may seem like inexplicable behavior. For example, family members may pass as nonfamily members. They may do this by disownership. I hesitate to use the following examples because they are so idiosyncratic. However, what I have found is that many illnesses lead to unique responses by family members. In some situations, illness brings out and magnifies the pathology that was. The following are examples of this.

When Mary's husband found out that she had nonhodgkins lymphoma, for several months he tolerated his wife's illness and the difficult aftermath of the treatments. When he realized that the recovery was slow and perhaps never-ending, he passed as a nonfamily member. He did this by leaving and, late, divorcing her.

Another extreme example: A physically ill man and his family were disinherited. The reasoning: because he was ill, he would be of no use to his aging mother. This man could not continue to relate to the narcissistic mother who, upon his being diagnosed, treated him like a non-son. He then did what she unconsciously planned; he freed her from being there for him while he lived as an ill person. The story continues. The adult man's only sibling could have stepped forward and protected his ill brother. However, he was in line to profit from his brother's disinheritance. The well sibling chose to steal. He used a sophisticated technique for his theft, and it was silence. He joined his mother in the abandonment of the sick man. He, too, chose to see no illness, hear no illness, and speak no illness. He chose to live as an only and wealthy son.

Self Typology

Contemporary psychoanalytic thinking (e.g., Pizer, 1998) conceptualizes the self as being divided among multiple islands of relational experience and, in the healthy individual, the islands are held whole by the mental facility to bridge paradox (Bromberg, 1993). Stay with the islands. As I see it, illness is like a tsunami. When the wave of illness hits, some of the self islands may be entirely submerged by the heave. When the wave is titanic and prevailing, one self runs from the wave and can hear the water right behind. One is running toward the other side of the island, and when that self is halfway across, he finds that the water is in front of him too. The waves meet and a self goes under. In fact, many selves may go under. These islands of selves disappear from psychic view. As these selves go under, it may be difficult to recognize oneself. It is as if oneself is no longer and, in time, new and unfamiliar self-islands develop.

This is what illness does. It creates a whole new self-typology and leads to the work of negotiating a newly developed and developing landscape along with some old self-islands from the past. The work ahead with the tsunami-ridden self is mammoth, like the wave. Only passing can slow down the tsunami. Passing enables some of the self-islands of relational experience to be as they were prior to illness. By passing one keeps his well self alive and continues to be treated as well. Passing is a slow, gradual defense against death. It enlivens. It protects the alive self from annihilation. It is the falseness which keeps the passer alive. At the same time, however, passing deadens. It results in the passer feeling dead, disconnected, detached, and inauthentic. This is the paradox: While passing enables self-parts to be recognized, it simultaneously leads to the feeling of deadness.

Those in treatment, can be helped to access authentic emotion and aliveness and to feel the power of authenticity. But there is a challenge for the analyst. Illness is chilling and therapists are not immune to the terror of illness or to the dread of death. We need to work to realize this and to acknowledge how challenging work with the physically ill can be. Collusion around passing must be avoided. Authenticity is called for. Healthy selves and ill selves have a place in our consulting rooms. The goal is for authentic communication and for the holding of all the selves.

In closing, I have talked about one aspect of the trauma of physical illness, that of passing. My hope is that scientists and practitioners will place physical illness on the trauma map and that scientists and practitioners will work together to conceptualize a scientifically-informed approach to practice with the physically ill and their families and a practice-informed approach to research on the trauma of physical illness.

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TRAUMA PSYCHOLOGY NEWSLETTER

ASSOCIATE EDITOR
Position Announcement

I. POSITION PURPOSE

Under direct supervision of, and collaboration with, the Newsletter Editor, assist in the publication process of the Division 56 newsletter and performing liaison duties with editorial board members and newsletter contributors.

II. PRIMARY DUTIES AND RESPONSIBILITIES

1. Coordinating submission and review processes for each newsletter.
2. Writing letters to various professionals involved in the publishing field.
3. Updating author, reviewer, and general office files.
4. Corresponding with authors, reviewers, and publisher.
5. Other necessary activities related to the editing and publishing of the Division newsletter.
6. Assume position of Editor once current term ends.

III. KNOWLEDGE, SKILLS, AND ABILITIES

1. Maintain a professional appearance and demeanor and ability to effectively interface with the public at a professional level.
2. Ability to effectively communicate and accurately articulate verbally, in writing and electronically.
3. Ability to coordinate staff with regard to overall newsletter goals.
4. Working knowledge of APA format.
5. Ability to successfully work individually and as a team member.
6. Skill to achieve and maintain attention to detail.
7. Ability to utilize sound judgment to achieve positive problem solving and reach successful decisions; knowledge to know when to consult a supervisor.
8. Ability to effectively work through a supervisor or manager.
9. Ability to follow established procedures and guidelines.

IV. EDUCATION AND EXPERIENCE

Doctoral degree required. Must have excellent verbal and written communication and organizational skills and proficient knowledge of Microsoft Word, Excel, and WordPerfect. A successful candidate will possess one or more of the following qualifications: skill, experience, or interest in trauma psychology. Optimal candidate will be someone who is efficient, self-starting, detail-oriented, and a quick learner. Prior knowledge of newsletter and journal articles and editorial process is a plus. Please have professional references available.

If you are interested in applying, please send a letter of interest and experience, along with a copy of your CV, to Newsletter Editor, Topher Collier (DrTopherCollier@aol.com) by January 15, 2008.

2008 CEMRRAT Grants

The APA Commission on Ethnic Minority Recruitment Retention and Training (CEMRRAT) Task Force is seeking proposals for 2008 CEMRRAT GRANTS.

These small grants are intended to serve as "seed funds" to energize, empower, and support the efforts of individuals, organizations, and educational institutions committed to enhancing ethnic minority recruitment, retention and training in psychology.

Proposals will be accepted, beginning January 1, 2008, from state psychological associations, APA divisions, departments/schools of psychology, APA boards and committees, other entities of organized psychology, or individuals. And funds will be available on a first come-first served basis.

For more information, including application instructions and the funding categories See the full RFP at: www.apa.org/pi/oema/programs/CEMRRAT2%202008_request_for_proposals.pdf.

Suinn Minority Achievement Award Nominations

The APA Commission on Ethnic Minority Recruitment Retention and Training (CEMRRAT) Task Force is accepting nominations for the Suinn Minority Achievement Awards.

The Suinn Award is given to departments of psychology who have demonstrated excellence in the recruitment, retention, and graduation of ethnic minority students. Nominations are submitted by student(s) within the particular psychology graduate department and/or program.

The call for nominations is available online at: http://www.apa.org/pi/oema/programs/cemrrat2.html.

With support from a grant by the Arcus Foundation National Fund, AFFIRM: Psychologists Affirming Their Lesbian, Gay, and Bisexual (LGB) Family has been working on a project to enhance the training of graduate students in clinical psychology.

Voicing their concern about the lack of exposure to LGB issues in their training, graduate students have written to the APA Committee on Accreditation, urging them to recognize exposure to the literature on sexual minorities as an important part of the APA diversity requirement.

AFFIRM has put together a carefully selected list of readings on LGB issues and sent them to Directors of Clinical Training, asking them to distribute it to their faculty. The topics covered include child/development, couples/family, ethics, psychopathology, and therapy.

In order to make these references available to an even larger audience, AFFIRM has also just posted them on its Web site, together with abstracts for each. To facilitate ease of use, a PDF can be obtained for each reading through PsycINFO, by contacting the author, or by e-mailing marvgoldfried@gmail.com.

You are invited to visit the AFFIRM Web site at: www.sunysb.edu/affirm. Go to "Announcements" for further information on the project, and then click on "Bibliographies."

Laura Brown responds to NPR's report on online child pornography ring and ex-*Times* reporter Kurt Eichenwald.

The link to hear Robert Siegel read the letter is: http://www.npr.org/templates/story/story.php?storyId=15636567

The link to the original story is: http://www.npr.org/templates/story/story.php?storyId=15430924

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Summit on Violence and Abuse in Relationships: Connecting Agendas and Forging New Directions

February 28-29, 2008 Bethesda, Maryland

Alan Kazdin, PhD, President-Elect of APA, has selected this summit as part of his presidential initiative. Topics include Intimate Partner Violence, Child Maltreatment, Children Exposed to Violence and Abuse, Elder Abuse, Gender-Based Issues, Cultural Issues, Ethnic Minorities, Substance Abuse, and related themes. The focus will be on What We Know, What We Need to Know, and Where Do We Need to Go with respect to Research, Intervention, and Prevention. The program will consist of a number of plenary speakers and break-out groups to discuss relevant topics.

Conference Schedule

February 28: Opening Plenary, Poster Session, Networking Reception
February 29: Summit Programming

Coordinators

Jackie White, PhD, President-Elect, Div 35
Bob Geffner, PhD, President-Elect, Div 56

Preliminary Keynote Presenters

Arun Gandhi, Mary Koss, PhD, Jacquelyn Campbell, PhD, RN, Rodney Hammond, PhD, David Finkelhor, PhD, and Jacki McKinney

Host Hotel

Hyatt Regency Bethesda (888) 591 1234: *Reservations link at* www.reisman-white.com (special conference rate code- **G-TPSY)**
$189 single/double

- In addition to the two lead divisions sponsoring the conference, Division 35, Society for the Psychology of Women and Division 56, Trauma Psychology, preliminary co-sponsors of this summit are: Robert Wood Johnson Foundation, Centers for Disease Control (CDC), International Society for Research on Aggression, and the University of Kentucky's Center for Research on Violence Against Women. The following APA divisions and organizations are serving as collaborators:

- **8 –** Society for Personality and Social Psychology
- **9**- Society for the Psychological Study of Social Issues
- **17**- Society of Counseling Psychology
- **22**- Rehabilitation Psychology
- **27**- Society for Community Research, and Action: Division of Community Psychology
- **28**- Psychopharmacology and Substance Abuse
- **37**- Society for Child and Family Policy and Practice
- **39**- Psychoanalysis
- **41** – American Psychology-Law Society
- **43**- Family Psychology
- **45**- Society for the Psychological Study of Ethnic Minority Issues
- **48**- Society for the Study of Peace, Conflict, and Violence
- **50**- Addictions
- **51**- Society for the Psychological Study of Men and Masculinity
- Interdivisional Task Force on Child Maltreatment Prevention
- National Center on Domestic Violence, Trauma and Mental Health

The Institute on Violence, Abuse and Trauma at Alliant International University is a co-sponsor of this Summit, and is responsible for the Continuing Education program. Up to 8.5 hours of CE credit is are available for psychologists, social workers, marriage and family therapists, nurses, attorneys, substance abuse and other counselors.

For additional information and to register for this summit, go to www.APAviolencesummit.org or call (512) 845-9059

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CALL FOR POSTER SUBMISSIONS

for the

SUMMIT ON VIOLENCE AND ABUSE IN INTERPERSONAL RELATIONSHIP: CONNECTING AGENDAS AND FORGING NEW DIRECTIONS

February 28-29, 2008
Bethesda, MD

We are pleased to announce a call for Posters presenting the most current and cutting edge research, interventions, and prevention programs related to all aspects of relationship violence (such as child abuse, sexual violence, elder abuse, and intimate partner violence in teens and adults). Posters that present unique scholarly perspectives on violence are particularly encouraged. Special attention will be given to proposals that address gender, ethnic minorities and cultural issues, intersecting identities and vulnerability for victimization, substance use, and integrating types of violence.

Accepted Posters will be included in a unique setting in which poster authors and conference participants will have the opportunity for lively interaction, discussion, and networking. Poster presenters are encouraged to be prepared to take advantage of this unique setting to engage conference participants in scholarly discussion. Posters will be presented Thursday evening, Feb 28, 2008 during the Summit-wide networking reception. This Summit is co-sponsored by the American Psychological Association, 14 of its divisions, various community coalitions, federal agencies and organizations. The summit is a central theme of Alan Kazdin's APA presidential initiative.

Abstract Submission

Submit poster abstracts by **EMAIL *no later thanDec.* 21, 2007**. Abstracts will be reviewed and selected based on relevance, quality, and unique scholarly contribution to the Summit theme. Poster authors will be informed no later than Jan. 11, 2008.

Poster Submissions must include:

- title, authors and affiliation
- 50 word summary (for publication in the conference material)
- 250 word summary of the topic, the research questions/goals, findings, and implications for practice, public policy, and theory advancement
- Author email, mailing address, and phone contact information

Poster abstracts should be submitted to:

Email: CAFS@indiana.edu
Attn: Relationship Violence Summit Poster submission
Questions/further information regarding the poster process to CAFS@indiana.edu

Important Information

- Each presenter is responsible for his/her own travel and lodging expenses
- Upon acceptance, each presenter is required to register for the conference at a reduced fee; there will be some opportunities for volunteer work to waive complete fees
- Graduate Students: There are many opportunities to volunteer and have your conference fee waived!

Conference Information and Registration Information:

www.APAviolencesummit.org *(click on "conferences" on the top tab)*

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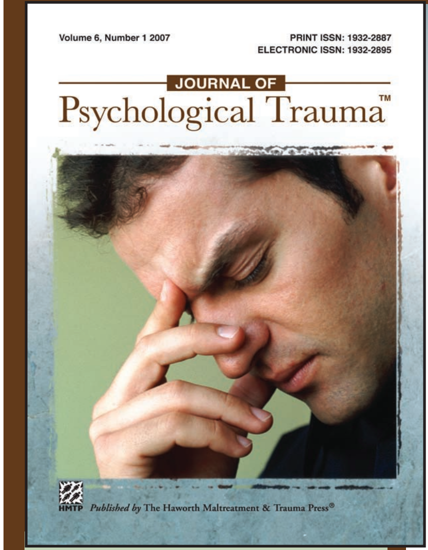

JOURNAL OF Psychological Trauma™

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Nova Southeastern University, Center for Psychological Studies, Fort Lauderdale, Florida
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The **Journal of Psychological Trauma** (retitled from the *Journal of Trauma Practice* to better reflect its focus) provides the latest developments in practical knowledge, research, and effective treatments to help those clients with psychological trauma. Academics, researchers, and clinicians use this superb peer-reviewed journal as a forum to provide the most current information and research findings about various challenging aspects of psychological trauma. This journal, published quarterly, enables practitioners to apply the latest scientific methodology and research findings to day-to-day practice. Educators, students, and frontline clinicians get the latest practical clinical information, theoretical treatises, literature reviews, case studies, and empirical research studies. The **Journal of Psychological Trauma** provides useful knowledge and skills to help traumatized clients live more comfortably and productively, and ultimately to gain greater satisfaction in their lives.

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CURRENT CONTENT HIGHLIGHTS

- Global Ratings of Essays About Trauma: Development of the GREAT Code, and Correlations with Physical and Mental Health Outcomes *(Bridget Klest, MA, and Jennifer J. Freyd, PhD)*
- Acute Stabilization in a Trauma Program: A Pilot Study *(Colin A. Ross, MD, and Sean Burns, MA, LLP)*
- A Comparison Study of Coping, Family Problem-Solving and Emotional Status in Victims of Domestic Violence *(Caroline Clements, PhD, and Richard L. Ogle)*
- Preliminary Results of a Police-Advocate Home-Visit Intervention Project for Victims of Domestic Violence *(Robert L. Casey, PhD, Miriam Berkman, Carla Smith Stover, Kelley Gill, Sasha Durso, and Steven Marans)*
- Trauma and Serious Mental Illness: Is the Pendulum About to Swing? *(Steven N. Gold, PhD)*
- Childhood Trauma and Psychosis: The Genie is Out of the Bottle *(Paul Hammersley, BA, MSc, BABCP, RMN, John Read, PhD, Stephanie Woodall, BSc, MSc, RMN, and Jacqueline Dillon)*
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PAD07

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Edited by Dr. Robert A. Geffner, Founder and President of the Family Violence and Sexual Assault Institute, President of Alliant International University's Institute on Violence, Abuse, and Trauma in San Diego, CA, and Dr. Joyanna Silberg, Coordinator of Trauma Disorder Services for Children at Baltimore's Sheppard-Pratt Hospital, the **Journal of Child & Adolescent Trauma** examines the effects of childhood maltreatment; loss; natural disasters; political conflict; exposure to or victimization from family or community violence; ethnic, gender, or class discrimination; and physical injury, diseases, and painful or debilitating medical treatments.

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- Real Life Heroes Pilot Study: Evaluation of a Treatment Model for Children with Traumatic Stress *(Richard Kagan, Amber N. Douglas, John Hornik, and Suzannah L. Kratz)*
- The Role of Internal and External Protective Factors in Low-Income, Ethnic Minority Children's Psychological Reactions to Community Violence Exposure *(Dawn H. S. Reinemann and Phyllis A. Teeter Ellison)*
- Current Practice of Family-Based Interventions for Child Traumatic Stress: Results from a National Survey *(Patricia Lester, William Saltzman, Vera Vine, W. Scott Comulada, Rise Goldstein, Margaret Stuber, and Robert Pynoos)*
- Emotional Reactions, Peritraumatic Dissociation, and Posttraumatic Stress Reactions in Adolescents *(Grete Dyb, Ned Rodriguez, Melissa Brymer, William Saltzman, Alan M. Steinberg, and Robert S. Pynoos)*

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PAD07

Mission of Division 56
Trauma Psychology

The Division of Trauma Psychology of the American Psychological Association (APA) provides a forum for scientific research, professional and public education, and the exchange of collegial support for professional activities related to traumatic stress. Our goal is to further the development of the field of psychological study of trauma and disaster in its scientific, professional, educational, and public policy aspects. The Division also helps to advance scientific inquiry, training, and professional practice in the area of trauma treatment and research as a means of furthering human welfare.

We welcome all psychologists and other individuals in the mental health and other fields who have an interest in trauma psychology.

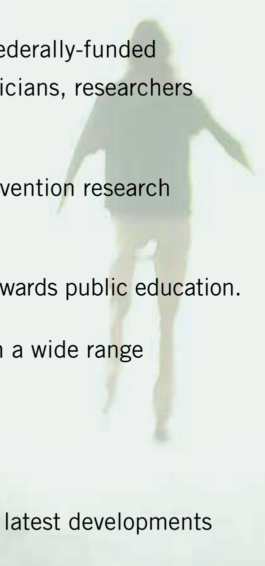
Services to APA and its Membership

Training: Training, developing knowledge and sharing of expertise in the area of traumatic stress exposure and PTSD.

Health Service Delivery and Research: Work toward improving culturally sensitive service delivery in mental and physical health for people with trauma exposure; development of an integrative journal for the field in an effort to further a more practice-informed approach to trauma research and a more scientifically-informed approach to trauma practice; opportunity for scientist-practitioners, practitioners, and scientists to work together to develop knowledge about trauma.

Consideration and Integration: Consideration and integration of diverse areas of study such as: combat, rape, domestic violence, child physical and sexual abuse, refugee, torture survivors, prisoners of war, community violence and occupational traumatic stress; exploration of underlying principles leading to the development of psychopathology, disability and distress, resilience, and mental and physical health; integration of clinical knowledge and research.

Academic Support: Support for academic researchers studying these diverse areas; possible development of an integrative journal for the field in an effort to further a more practice-informed approach to trauma research and a more scientifically-informed approach to trauma practice.



Funding: Work in conjunction with federally-funded centers of excellence to support clinicians, researchers and students in the field.

Prevention: Develop and support prevention research and practice.

Public Education: Projects working towards public education.

Publications: Producing materials on a wide range of trauma-related topics.

Membership Benefits

- Members keep up-to-date on the latest developments in trauma psychology
- Members also get 30 % discounts on journals in the field of trauma
- A Trauma newsletter
- Participation in the Division's annual meetings
- Voting privileges to elect representatives

Yes, I want to join Division 56!
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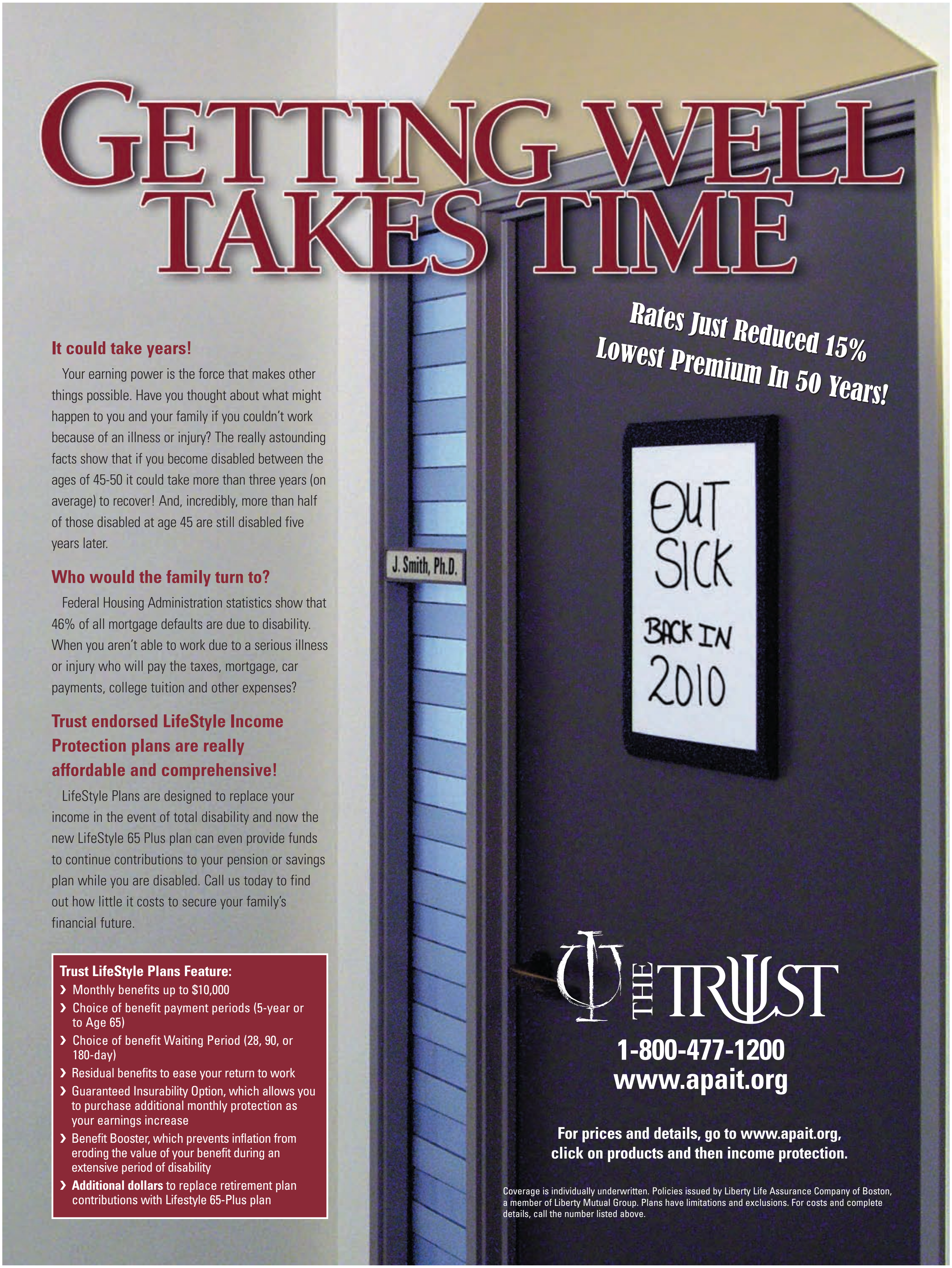
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December 15, 2007	Winter 2008	February 2008
March 15, 2008	Spring/Summer 2008	May 2008
September 15, 2008	Fall 2008	November 2008

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