

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

NEWSLETTER

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Presidential Voice

State of the Division

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As we finish our second year as a full Division of APA, it is my pleasure to thank the outgoing Board members who have done an excellent job helping us move forward: Judie Alpert (Past President, and our first president!!), Terry Keane (Member-at-Large), and Toby Kleinman (Professional Affiliate Representative). The Board for 2009 which begins January 1, is outstanding, and as Past President, I appreciate the opportunity to work with all of them. We welcome Steve Gold as President, Laura Brown as President-Elect, Harriette Kaley as a Member-At Large, David Albright as Professional Affiliate Representative, and Lisa Cromer as Early Career Psychologist Representative. Those who are leaving the board are doing so in title only since once a board member, always an honorary one for the division!!!

This year, many important milestones were accomplished. Our

membership passed 1,150 members, and we were only 1 of 6 divisions to not lose membership (in fact, we are continuing to increase membership!). We now have active early career psychologists as well as students, and we plan to add even more during the coming year. We have already

been involved in three CODAPAR grants and have applied for additional ones for 2009. Last February, The **Summit on Violence and Abuse in Relationships: Connecting Agendas and Forging New Directions** was a success with 450 people attending in our first year. Receiving wide

publicity throughout APA, it involved 19 divisions, and Division 56 was a lead division for all of this. Our stature has increased substantially as a result.

Due to the efforts of many Executive Council members, we will also have a new APA journal (*Psychological Trauma*) that will begin in 2009. It will be edited by Steve Gold, and associate editors will be Christine Courtois and Kathleen Kendall-Tackett. This quarterly APA journal only costs



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(see under **Diversity and Multicultural Committee**)

My Thanksgiving

Judie Alpert, Division 56 Past President

My term of office is almost over, and this is the last time I will be writing for the newsletter as Division 56 Past President. While it is not yet Thanksgiving, it is a time for heartfelt thanks.

While I cannot possibly mention all the folk who contributed so generously, energetically, and creatively to the Division, I must name a few folk. While there were many who worked with me in making the Division a reality, I must single out one person above all others and that is Bob Geffner. He worked tirelessly to make the division a reality. It is for that reason that I have given Bob the nickname "Bob the Builder."

Others who must be singled out include Terry Keane, Laura Brown, Kathy Kendall-Tackett, Steve Gold, and Melba Vasquez. These folk worked tirelessly on behalf of our Division. In fact, all the Executive Committee members worked hard. One who held a most demanding job and whose productivity is so visible is our



Judie Alpert, PhD

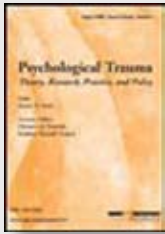
membership chair Sandra Mattar. She knows how to make things grow. Another is Topher Collier, our newsletter editor. Topher has created one of the finest newsletters I have ever seen; I hear this from so many people. APA staff who worked most closely with us and who were always gracious and generous include Gwen Keita and Sarah Jordan. But, please forgive me for not mentioning each individual member of the Executive Committee. While they all deserve heartfelt thanks, I do not want this final column to read like a list of "who's who" in Trauma Psychology.

I conclude by saying that our new officers are a terrific group. Steve Gold is President-Elect and Laura Brown is President-Elect-Elect. Both are among the two hardest working and creative folk I know. As I consider all the newly elected officers, I am confident about the future of our Division. It is in competent hands.

Lastly, I thank our membership. I thank you for your help in establishing and developing one of the fastest growing and exciting Divisions within the American Psychological Association.

I'll see you around the "Trauma Division campus"!

New Division 56 Journal



The American Psychological Association Division of Trauma Psychology (56) is pleased to announce that it has established a Division journal, *Psychological Trauma: Theory, Research, Practice, and Policy (PT:TRPP)*.

The journal is published by the American Psychological Association and its editors, Drs. Steven Gold, Kathy Kendall-Tackett, and Christine Courtois, are dedicated to making it one of the top sources for current, reliable information about psychological trauma. The Division of Trauma Psychology is extending a call for papers, strongly encouraging researchers and authors with trauma-relevant manuscripts to submit them to *PT:TRPP*.

For more information about the Journal, please visit <http://www.apa.org/journals/tra/callforpapers.html>

In Libraries and Bookstores

Please send any 2008 publications by Division Members to Kathy Kendall-Tackett (KKendallT@aol.com) by **December 15, 2008**, as we are planning to include a list of member publications in our Winter 2009 issue.

Winter 2009 Issue



Topher Collier, PsyD

The *Trauma Psychology Newsletter* is accepting articles for the Winter 2009 issue. In addition to our regular features, we would like to have a special section covering the traumas of adoption. The deadline for submissions is **December 15, 2008**. 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.

"Connecting Agendas" Think Tank, September 2008

*Sylvia A. Marotta, PhD, Division 56 Representative
The George Washington University*

When approximately 40 representatives of organizations gather to set an agenda, the result can be both stimulating and overwhelming. Participating organizations at the September 12, 13th think tank included consumer movements like Promoting Awareness, Victim Empowerment (PAVE), complex federal agencies such as the Office of Violence Against Women in the Department of Justice and National Institutes of Drug and Alcohol, and the Centers for Disease Control, cross-disciplinary professional associations, and university centers and institutes. The think tank itself was a product of the National Summit on Interpersonal Violence that was held in Washington in February 2008 (See the Spring Division 56 Newsletter for a report on the summit, and its purpose of providing a forum to catalyze violence prevention). The summit called for continuing dialogue and collaboration and specific actions that would engage the public and set in motion a groundswell response. Each component of the ecology of interpersonal violence and abuse was to be engaged, from the individual to the community to the cultural context where violence continues. Since the summit several initiatives have been implemented or will soon be. A town hall focusing on summit initiatives was held during the American Psychological Association's annual convention in Boston; a violence prevention track during the convention focused on the issue as part of Alan Kazdin's Presidential Initiative; and a symposium presented by Summit participants will take place at the National Multicultural Summit in January 2009. The issue therefore has had considerable national prominence in the last year and hopefully will continue to make an impact as the outcomes of the think tank unfold.

As the title notes, the purpose of the think tank on interpersonal violence prevention was to develop a 3-5 year agenda for addressing this endemic public health problem. Participants were charged with developing an action plan that would bridge the disciplines and the types of violence, integrating research, practice, and policy that is respectful and inclusive of the experience of survivors across the lifespan. In the course of one and a half days, participants in large and small groups focused on seven major themes: Public awareness, training/mentoring, practice, research, funding, public policy, and community action/capacity building. Think tank leaders were Jackie White, representing Division 35, and Bob Geffner, representing Division 56. Ruth Fassinger's (Division 44) facilitation skills kept the participants focused and practical throughout the meeting. The action plan will be implemented and evaluated by small groups developed throughout the two days.

To illustrate the types of projects comprising the action plan, the public awareness task force will begin identifying national partners that will educate and engage the public on preventing violence, using successful models such as

the Susan B. Komen Race for the Cure. The campaign will be modeled after political campaigns and will be rolled out by the third year, and evaluated and revised by the fifth year. A second example of a task force action plan will encompass practice and research. This plan will use existing collaborations to build practices that are research-informed and contextual.

An eventual outcome might be to propose a national institute for violence prevention at the National Institutes of Health.

The next generation of research, practitioners, and policymakers will also be the focus of think tank initiatives. By the time the second Summit on Interpersonal Violence

takes place in 2010, the task force on training and mentoring will have developed benchmarks that identify gaps in existing training and education program and will propose a model for both undergraduate and graduate education. Eventually it is hoped that there will be some form of national standards for accrediting bodies to include as competencies for students and objectives for university programs.

On a very concrete level, think tank participants will collaborate on a special issue of a journal, and an ad hoc editorial board was formed to discuss content and process. A planning committee will undertake the agenda for the 2010 Summit on Interpersonal Violence, using existing meetings such as the Midwinter Multicultural Conference in 2009 to gather people who are traveling there with the object being to hold costs down. The think tank was held the 2 days prior to the annual International Conference on Violence, Abuse and Trauma, hosted by the Institute on Violence, Abuse, and Trauma (IVAT), in San Diego and many of the participants also presented papers at the IVAT, demonstrating the utility of combining resources to make an impact.

The agenda is ambitious, but the issue is relevant and solutions can be found. To borrow from the World Health Organizations ecological model for understanding violence, there is a role for everyone in addressing the problem. Individuals can behave in ways that decrease the risk, relationships can be developed to protect against violence rather than increase risk, communities can address population density or unemployment that contribute to escalating rates, and societies can examine their commitment to political structures that promote peace rather than conflict. As one survivor summed it up at the think tank, "In my family, I'll be the one to break the cycle." Families, communities, and societies might similarly say, "It is all of our business and we can all break the cycle." The newsletter will continue to provide updates on the many outcomes of the action plan.

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Sylvia Marotta

Call for Papers: Special Section on “Posttraumatic Stress Disorder and Trauma in Children and Adolescents”

The *Journal of Consulting and Clinical Psychology* (JCCP) invites submission of empirical papers and scholarly reviews that focus on research pertaining to posttraumatic stress disorder (PTSD) and trauma reactions in children and adolescents.

- The inspiration for this section was derived, in part, from
- the 2008 American Psychological Association (APA) Presidential Task Force on this topic
- APA resolution on The Psychological Needs of Children Exposed to Disasters
- APA resolution on Children’s Mental Health

Stress reactions resulting from different types of trauma (e.g., natural disasters, terrorism, child sexual abuse, community violence, medical trauma/injury) will be considered.

Papers may focus on

- risk and resilience factors, including potential variations among groups (e.g., sex, ethnicity/culture, socioeconomic status, age/developmental stage);
- issues of comorbidity and related trauma reactions;
- impact on adaptive functioning in children, youths, and families; and
- effective prevention and treatment interventions.

Preference will be given to papers that provide clear articulation of the conceptual or theoretical basis for the variables that are selected for evaluation in the research.

It is essential that papers directly discuss:

- a. areas of research need and important “next steps” that will help guide future research, prevention, and treatment efforts, and
- b. recommendations for disseminating information to stakeholders interested in helping children and their families in the aftermath of trauma, such as parents/caregivers, health-care providers, practitioners, policy makers, and government agencies.

Findings are intended to help inform the next generation of studies for PTSD and trauma reactions in children and adolescents, as well as the practice of psychologists working with children, adolescents, and families.

Manuscripts must be consistent with the submission guidelines; papers that do not follow the guidelines may be returned without review.

Submit papers electronically through the Manuscript Submission Portal, and request consideration for the Special Section in the cover letter.

To be eligible for inclusion in the Special Section, papers must be submitted by **January 15, 2009**; early submissions are encouraged. Papers that do not meet the deadline will be considered as “regular” submissions to this journal.

Questions should be addressed to the Journal Office via phone (305-284-8823) or e-mail to jccp.psy@miami.edu. <http://www.apa.org/journals/ccp/papercall-ptsd.html>

Carol D. Goodheart, PhD

My campaign platform and my lifetime work as a health psychologist heartily support the goals of Division 56 to promote advances in research, professional training, and clinical practice related to traumatic stress.

Trauma is a significant public health issue, often associated with cascading effects such as family disruption, addictions, and comorbid psychological/medical conditions. My orientation is rooted in that health perspective and involves the integration and collaboration of science and practice. I bring that perspective to my candidacy for President. The trauma part of my scholarship and practice in Princeton, New Jersey, focuses largely on medical trauma, especially for individuals and families coping with the effects and sequelae of aggressive medical treatments for cancer. Two of my books include chapters on trauma: *Living with Childhood Cancer: A Practical Guide to Help Families Cope* (APA, 2002) and the *Handbook of Girls' and Women's Psychological Health* (Oxford, 2006).

It is vital for our next President-elect to understand the coordinated agenda that drives APA forward. My vision for APA is the result of years of serving our organization as a leader and learning about its strengths and its potential.

My platform is a commitment to effective leadership on your behalf: the pursuit of economic advances, new partnerships, strengthened advocacy, increased diversity, and organizational responsiveness. As APA President, I will advance endeavors of importance to members. Here are two examples:

We must address our **members' economic pressures** more directly. Career-building is a practice issue, a science issue, an education issue, a diversity issue, and an early-



Carol D. Goodheart, PhD

career issue. The public is deprived, and even harmed in some cases, when they do not have access to the fruits of psychology. This means we must create stronger projects for economic success in competitive funding environments. **As APA President, I will focus on the economic success that is a necessary foundation to serving our nation well: a good practice for every clinician, a good grant for every researcher, a good job for every early career professional. I will support the 2009 Practice Summit vigorously as co-chair of the Task Force on the Future of Psychology Practice.** The goal of the Summit is to develop a comprehensive set of recommendations for sharpening our strategies to ensure the future of psychology practice.

Psychology has not yet achieved parity with medicine in the public eye. **As APA President, I will seek the development of a new think tank, an Institute of Psychology, on a par with the Institute of Medicine.** We need an Institute of Psychology that is as far reaching, powerful, & influential as the Institute of Medicine. I envision it as a *true* partnership among psychologist constituencies. It will provide a platform to showcase projects for the public that meet important criteria. It will provide a focus on a public health or social problem of significance to the country. It will provide an integration of all science that has bearing on the problem. It will provide a mechanism for the delivery of psychology services to address the problem. It will provide clear messages to policy makers, consumers, and public and private stakeholders. It will provide alliances with others to increase psychology's influence and move us forward.

As President, I will seek the input and collaboration of Division 56 to advance our discipline. I have the knowledge, experience, and proven track record to serve you well as President, and I hope that you will be interested in working together on our shared agenda for psychology.

See more at <http://www.CarolGoodheartForAPAPresident.com>.

I respectfully ask for your # 1 vote.

Carol

Jack Kitaeff, PhD, JD



Jack Kitaeff, PhD, JD

It was during my clinical psychology internship at Walter Reed Army Medical Center that I gained my first exposure to the clinical sequelae of severe stress and trauma. My interest in this area continued during the next four years as the chief psychologist of U.S. Dewitt Army Hospital, Fort Belvoir, Virginia. Much of my clinical work involved evaluation and treating stress disorders related to military service. However, I soon came to realize that clinically significant trauma and stress reactions resulted from situations quite

divorced from military service. These included domestic violence, rape, child physical and sexual abuse, community violence, and so-called "normative" male sexual socialization violence.

Things changed significantly for me on January 13, 1982, when Air Florida flight 90 crashed into the 14th Street Bridge in Washington, DC. Since this was located only a few miles from my duty station, I was involved in counseling military personnel who were involved in the horrific rescue operation. Ironically, two years later as a police psychologist for a northern Virginia police department I dealt with police officers who were first on the scene on the bridge and showed signs of delayed stress reactions. Around that same time I became interested in police officers who had been Vietnam veterans and their symptoms of post-traumatic stress disorder which was current and real for them on the

job every day. In 1985 I wrote an article for the Virginia Police Chief titled "Post-traumatic Stress in Police Officers who are Vietnam Veterans."

In police work, I have found that the ability to cope with stressful incidents depends on an officer's past experiences with trauma (e.g., stress inoculation); the presence of coping strategies for stress; availability of support networks (e.g., family, friends, and colleagues); and recognition of the dangers signs and symptoms of pathological reactions.

I have worked extensively with officers who have experienced shootings, life-threatening incidents, hostage situations, intense crime scenes and suicides. Stress responses and symptoms have been cognitive (confusion, difficulty concentrating, intrusive thoughts), physical (fatigue, headaches, disturbed sleep patterns), behavioral (withdrawal, acting out, or substance use), and emotional (anxiety or fear, depression, anger or guilt, or feelings of helplessness). In addition, flashbacks, nightmares and emotional numbing have been displayed in more severe cases. But trauma-related disorders are not limited to police officers or the military. Estimates are that almost 8 % of adult Americans will experience PTSD at some point in their lives, with women twice as likely to be victims as men (mostly due to domestic violence and abuse).

Considering the underserved need for trauma services, as president of the American Psychological Association, I would pursue the following initiatives:

- Appoint an education task force to investigate providing greater opportunities for trauma training in graduate psychology programs and in externship and internship settings;
- Vigorously support APA's Disaster Response

Network which helps provide mental health professionals to be onsite with emergency workers to assist with the psychological care of trauma victims.

- Provide proactive consultation to State Mental Health Directors to address the needs of the victims of trauma, whether such trauma stem from natural causes (e.g., hurricanes, tornadoes), accidental causes (e.g., airline crashes) or man-made actions (e.g. mass shootings, acts of terrorism).

- Initiate an inter-disciplinary task force in trauma to include psychologists, psychiatrists, social workers, counselors, and organizations such as the American Red Cross. This task force will encourage professionals with differing orientations to work together during emergencies. It will also facilitate needed research into trauma issues (such as why some people suffer physical and mental breakdowns when faced with overwhelming stress while others do not).

- Provide increased awareness of prevention of intimate partner violence, child maltreatment, elder abuse, and date rape, with specific attention to the role of gender and culture in such victimization.

- Further investigate "who is an expert" in trauma, and who is qualified to practice, teach and offer expert testimony.

I would work closely with Division 56 on all the above issues and expect considerable lending of expertise and consultation for these initiatives.

I respectfully request your support in the election for APA president.

Robert McGrath, PhD

My name is Robert McGrath, and I am a candidate for President of the American Psychological Association. In this brief statement, I would like to provide you with a sense of my vision for the association, how that relates to the study and treatment of trauma, and why I think I have the ability to bring that vision to fruition.

I realized many years ago that the reputation of psychology as a science and the survival of psychology as a profession depend upon our ability to enhance our visibility in society. This realization led me to become a participant in, in fact a leader of, the movement for prescriptive authority within psychology. Over the past eight years I have traveled the country helping states organize in support of the movement, providing input into the wording of bills, consulting on strategy, and testifying to legislators.

Ultimately, though, legislative activism and prescriptive authority must be part of a larger strategy for shaping the future of psychology. As scientists, psychologists can and



Robert McGrath, PhD

should provide the public face for empirically validated approaches to addressing social issues. This will enhance our reputation as a science and a profession. As practitioners, psychology, we can and should become active participants in shaping the healthcare system of the future. Given our knowledge of the behavioral and emotional components of medical conditions, and our training in diagnosis and assessment, in program evaluation and psychosocial interventions, and ultimately in prescriptive practice, psychologists have the potential to become the mental health and behavioral providers of choice within the collaborative care setting.

What are the implications of this agenda for the area of trauma in particular? One of the central healthcare issues our country faces is the quality and availability of trauma-related services for returning veterans. The treatment of trauma in this population is complicated by the involvement of concomitant neuropsychological impairment, and by the disruption of pre-existing social support systems during deployment. Here is an important opportunity for psychologists to operate in a manner that will both improve the quality of care and reflect positively on us as a discipline.

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We are for the first time beginning to understand how the brain responds to traumatic events, and how that response creates the potential for an enduring effect in the individual. We can combat the too-frequent assumption that PTSD is “just in their head” or malingered. We can educate the public about the prevalence of trauma reactions even in response to commonplace stressors. We can advocate with legislators to expand trauma-related services and research. As experts in the combination of psychosocial, neuropsychological, and pharmacological interventions we can educate the public and legislators about optimal treatment choices, and can identify ourselves as experts on the integrated biopsychosocial treatment of trauma-related distress. Finally, we can present the case for developing evidence-based treatments for trauma reactions.

In what ways am I the individual who can foster this aggressive agenda? I am in a distinctive position in terms of the extent to which I can bring together the scientific and applied roles in psychology, an integration that is central to the mission of your division. I am a full-time professor of psychology at Fairleigh Dickinson University, where I currently direct both an APA-approved scientist-

practitioner PhD Program in Clinical Psychology as well as a Postdoctoral MS Program in Clinical Psychopharmacology for licensed psychologists. I am an active researcher, with more than 150 publications and presentations mainly in the areas of assessment, measurement, methodology and professional issues. Despite my academic career, I am the Past President of Division 55 (American Society for the Advancement of Pharmacotherapy), a division strongly identified with advancing the status of practitioners. This ability to bridge the gap between scientists and practitioners, as well as my appreciation of the legislative process as it affects psychology, is essential for developing a coherent approach to advancing the field’s reputation.

Through my legislative and advocacy efforts, I have worked closely with a number of the members of Division 56 who understand that in these challenging times we must play a greater role in the decision-making process surrounding healthcare. I am proud of those relationships, and I hope the members of this division see in my platform a strong basis for their efforts to improve trauma-related research and treatment.

If you would like to read more about my platform, please visit my website, www.bobmcgrath.org. I look forward to the opportunity to help Division 56 advance its agenda as President of the American Psychological Association.

Steven Reisner, PhD



Steven Reisner, PhD

I have been involved in the field of trauma psychology for as long as I have been a psychologist. In fact, given our understanding of the inter-generational experience of trauma, one might say that my involvement in trauma psychology began even earlier, with my parents’ experience of the Holocaust. This legacy inspired both my desire to help people who have suffered trauma and my curiosity into what leads certain people to act cruelly and others to act decently in the face of terrible circumstances.

I began work as a psychologist in a hospital specializing in addictions and eating disorders; in other words, I began my career working with traumatized people. When I left the hospital and started a private practice, my area of specialization was the “difficult to treat” patient, particularly the suicidal, the self-destructive, and the so-called borderlines. Again, what these categories really described was trauma.

For the last decade, I have branched out in a number of directions, and each of these, it seems, involves trauma psychology. In 2000, I became Senior Faculty and Clinical Supervisor at the International Trauma Studies Program at NYU. Our program offered a comprehensive perspective on trauma and its treatment, including individual, family, community, ecological and national trauma, from biological, sociological, psychological, and political perspectives. Our international student body consisted of psychologists, physicians, UN and international NGO staff, art therapists,

photojournalists, lawyers, and others, all with a common interest in learning to work well with traumatized people. I was responsible for coordinating and facilitating both the academic program and the clinical supervision. It was not unusual to have group supervision sessions in which students from three or four different continents would present clinical issues in trauma. In one especially moving class, where we discussed how to help victims of genocide, an American woman described a women’s knitting group she belonged to, that sent sweaters and shawls in solidarity to Bosnian women during the Bosnian war. She said that it was an act of faith, because they never knew if the shawls were received. A Bosnian psychologist in the class spoke up and described receiving the shawls and how the gift helped Bosnian women feel that someone, somewhere, understood their suffering and truly cared.

In an earlier career, I was a theater director and actor; I worked on plays at Lincoln Center, the Public Theater and La Mama ETC. Not surprisingly, much of that work focused on the impact of traumatic events, particularly those involving political violence and social upheaval. I adapted and directed a story by Polish Auschwitz-survivor, Tadeusz Barowski, and I won an Obie award for collaborative work on a play about exile, entitled *Tourists and Refugees*.

Recently, I have begun to combine psychology, international trauma work and theater, to address trauma arising from political violence and exile. I helped create plays with Chilean torture survivors living in exile in New York City and with Kosovar refugees returning to Kosovo from refugee camps after the war. I believe that certain traumas have a socio-political component that must be dealt with both publicly and privately, so as to address the political

and historic aspects of the experience, as well as individual suffering. Theater provides an excellent forum for public discussion, transformation and social healing. (Please see my paper on the subject, entitled "Private Trauma/Public Drama: Theater as Response to International Political Trauma," in The Scholar and Feminist Online [<http://www.barnard.columbia.edu/sfonline/ps/reisner.htm>].)

It is because of my work as a trauma psychologist that I have been so terribly dismayed at the role of psychologists in America's cruel treatment of detainees. For those who may not know, government documentation has now revealed that psychologists were extensively involved with the military and the CIA in developing and overseeing abusive interrogation techniques and in supervising detention conditions aimed at

destroying detainees in body, mind, and spirit. Unfortunately, the APA continues to support psychologists' roles in these detention centers, even at sites that refuse International Committee of the Red Cross inspections, and are deemed in violation of human rights, international law and the US constitution.

I ask members of the Trauma Division to support my candidacy for President of the APA because I will be a strong and informed voice in support of Trauma Psychology, and because I will work to ensure that psychology itself is not used to perpetrate trauma, in either domestic or national security settings.

For more on my position on these and other issues, please visit my website: www.reisnerforpresident.org.

Ronald H. Rozensky, PhD, ABPP

Thank you for the opportunity to present my credentials in trauma psychology to the Division, to describe the importance I see for trauma psychology in my proposed presidential initiative in "psychology and public health," and to ask for your support and #1 vote as the next President of the American Psychological Association.

I was director of the community mental health services at the Evanston Hospital in Illinois in the late 1980s to the late 1990s. This responsibility included our hospital-based crisis intervention team. In May of 1988 a shooting occurred in an elementary school in Winnetka, Illinois where one child was killed and several others wounded. I responded first to the emergency room where the paramedics were bringing in the wounded, then was taken by the police to the school to help with the initial crisis response. I was involved in clinical follow up work within the community in the months to follow as well as carried out research looking at the effects of the event on the public safety personnel who responded.

A couple of years later a tornado struck Plainfield, Illinois, and the Illinois Psychological Association asked me to coordinate the activities of our members responding to that traumatic event. Psychologists from around the state responded and as result we crafted one of the first agreements between a state psychological association and the Red Cross for ongoing training and a network of responders. That program became one of the first to become part of the APA's Disaster Response Network.

When I relocated to the University of Florida in the late 1990s I applied for and received a \$1million grant from SAMHSA to found the National Rural Behavioral



*Ronald H. Rozensky,
PhD, ABPP*

Health Center whose initial mission was to create training materials to help rural county extension agents across the country become prepared for disaster response situations. Our Center staff published "Triumph over Tragedy," a 258 page manual plus DVD, focusing on disaster preparedness and response that was distributed nationally. Staff from our center responded to hurricanes in Florida, to Katrina, and as volunteers post 9-11. Currently I am working on a collaborative program with the University of Florida's College of Public Health and Health Professions and College of Design and Planning (architecture) and an institute in India on an international certificate program in disaster management. Thus, as a charter member of Division 56 I have trauma psychology in my professional genes.

As APA President one of my initiatives will be "Psychology and Public Health: Practice and Research Opportunities." Clearly, for me, disaster preparedness and post disaster/trauma management are important public health issues no matter whether we are speaking of human-made or natural disasters. I would see trauma psychology having a key role in that presidential initiative including highlighted programming at our convention.

I am Board Certified in Clinical and Clinical Health Psychology, having been in practice for over 25 years. I am currently Professor and Associate Dean for International Programs in the College of Public Health and Health Professions at the University of Florida, having served there as chair of the Department of Clinical and Health Psychology for 8 years. I was chair of both APA's Board of Professional Affairs and Board of Educational Affairs and served on the APA Board of Directors.

My presidential initiatives and goals for psychology's future along with my practice, research, public service, educational & academic history and qualifications can be found at www.RozenskyforAPAPresident.com.

Thank you.

Treating War Trauma in Israel: Lessons for the United States

Ilene Serlin

We in the United States are already facing enormous human consequences from the war in Iraq, and preparing to deal with psychological issues of returning veterans. Israel is, unfortunately, a country that is expert at dealing with psychological trauma and we can learn from their experience. This paper will discuss the prevalence of combat stress in Israel and introduce treatment interventions that can be applied to psychological treatments in the United States.

Holistic Health and Group Dynamics at Lesley University

Coming initially to teach in Israel in 1986, I soon discovered that trauma in Israel is ubiquitous. Twenty-two years later, this past July 2008, I came to teach a course in Holistic Approach to Pain and Stress to students in a masters program at Lesley University. In the group process, we learn to use the support of the group to deal with any event that arises during the group. This morning was significant in the fact that the two soldiers were being returned in the prisoner exchange with Hezbollah. The students were unable to focus on much else, so we looked for ways to bring the moment into the group. Normal students, they were nevertheless showing signs of trauma from the accumulated effects of war.

I normally start sessions with a short meditation to help the students leave their everyday hectic worlds behind and make the transition into the group space. The meditation I use is mindfulness meditation, without content.

This morning, the group asked one if its members to lead the meditation. She was a strong woman from an Orthodox religious background. Two other religious women from the group joined her, and they brought in prayer music and readings. I had worked with Herb Benson and Joan Borysenko in Boston in the mid 1980s with dying people in nursing homes just as Benson's book on the *Faith Factor* came out, and had witnessed the difference in power between using abstract meditation and prayer from people's own traditions. As a Jew, I am very interested in learning about prayers of healing from my own tradition, and in fostering collaborations between religious and non-religious peoples in the Middle East. The grieving process brought all mothers together, religious and non-religious. Empowering group members to take leadership in the group and helping groups work with cultural diversity are also parts of the healing process, so I was glad to participate in the collaborative opening prayer/meditation. The religious woman leading this meditation noted: "Our group by that time had been studying together for a year in significant courses on dynamics, yet the topic of religious and secular persons never came up. It is fascinating to think that it was work on movement that broke the barrier and opened the door to this discourse" (Mor-Yosef, 2008).



Ilene Serlin

During the prayer/meditation, many people were crying. We then stood in a circle, swaying to the music, holding each other and crying. One member burst out with new news—two caskets were returned. Sobs broke out, especially among a few group members who were mothers of soldiers the same age as the ones being returned. Some group members expressed their feelings that the exchange was especially cruel since, although most people believed that the soldiers were dead, false hope was spread that they might still be alive.

Another group member had brought a reading about hope and the possibility of daring to hope for hope. We talked about the need for confrontation with death in an existential approach to group therapy. We had read Yalom's perspective on the importance of the confrontation with mortality, real and metaphorical, in order to take risks and live fully. Using the arts to develop a spontaneous ritual around death, we lit a candle, stood in a circle crying, sharing stories and memories.

After the break, the group theme turned to death and rebirth—of hope: How to find and celebrate hope. We chose music—one of religious women who had led had music that spoke of hope to her. It was high energy and had strong rhythms and was comfortingly familiar to the group and its cultural context. The group danced in a circle, beginning to laugh and play together. I supplied scarves (I come with props), and the group members played with the scarves—tying them together as jump ropes, expressing freedom, waving them, connecting in pairs and subgroups with the scarves. We ended with exhilaration and freedom.

In the processing after this experience, one of the mothers expressed a hope that there would be such a group for the mothers of soldiers. With encouragement from the group, she began to explore the possibility that this is the kind of group she wants to create in Israel, and that this might be her way to transform despair into hope.

Another student described the power of the multi-modal approach:

The product, the finished picture or the actual dance, were of no consequence. The journey that took me to a safe space where my nonverbal creativity was released, processed and healed was the ultimate product. The confidence that I gained to use my body, hands and imagery to express and communicate on a level that words could not explore brought about a state of peace and healing.

From the point of view of transference, the morning was powerful for me on many levels. On one level, it reminded me of my first experience coming back to Israel after a long absence from my own traditions, and how naive I had been to the reality of trauma in Israel. I returned to Israel in 1986 after a many year absence to teach, and was doing an expressive therapy group. One of the women ran out of the room crying, and the group told me who she was and why she reacted so strongly. Her name was Smadar Haran, and her husband and daughter had been killed by a

terrorist in front of her. She had put her hand over her other daughter's mouth so tightly to keep her from screaming that she inadvertently killed her own daughter. The terrorist who did this is Samir Kuntar, just the one who was that very day being released by Hezbollah, and most Israelis were terrified that he is loose again. Trauma recycles through time and generations, connecting all of us.

Also, during this trip, I revisited Kfar Hyarok, a small village where I lived during the summer when I was 14 years old. I came back a Zionist, dreaming of creating the perfect democracy in Israel. As I got older, my own growing realism and cynicism was mirrored by Israel's complex relationship to power, land, and corruption—no longer the ideal society. This trip for me was a return home, finding ways through my own cynicism and that of many of my Israeli friends, to some kind of possibility of hope or transformation. I believe that we cannot do this work without being very aware of our own countertransference responses, and can use these to work more authentically and empathetically.

Selah

Selah is housed in a delightful, renovated blue and white building in Neve Tzedek, one of the earliest old quarters of Tel Aviv. As Ruth Bar-On, the founder, greeted each volunteer and staff person with equal warmth, the feeling she conveyed was not of an institution, but of a family with a generous earth mother.

We began our meeting with staff and volunteer introductions. Since each person's contributions were connected to his or her own personal experience, his or her introduction also told us of the services offered at Selah. However, only about half the staff were present; many worked in the field providing emergency services, in Sderot and in the northern region. While other organizations provided trauma recovery services, Selah specialized in working with immigrants and underserved populations, including some visiting tourists and foreign workers; for example that day they helped a woman from Sri Lanka, alone in the country, who was in a bus explosion in Jerusalem at the beginning of July 2008, and had her toes amputated. All work is done with individuals, often in a most practical way; another example, an Ethiopian without medical insurance who lost an eye due to virus, was provided by Selah with an artificial eye. Selah believes that the first stage of trauma relief is to give both emotional and practical support and help individuals stand on their own feet. This process is followed by individual longer-term support where necessary. Specific populations, such as orphaned children, being raised by grandparents/older siblings/aunt and uncle, also join support groups. Selah also provides workshops for professionals on culture sensitive issues, orientation trips in the country for new immigrants, and healing retreats in natural settings.

Of the staff members and volunteers who came to the meeting, we met:

- Ruth Bar-On—Selah's founder and Director, was initially involved in the struggle to get Jews out of the Soviet Union as head of the Council of Soviet Jewry.
- Anna Krakovich—Selah volunteer, originally from the Ukraine. Anna was seriously wounded in a terror

attack in 1994, and was hospitalized for almost a year. She was helped by Selah during her hospital stay and her recuperation, and works with the Russian immigrants in disaster situations. She says: "part of healing is to help others." The message from Selah is: "Even if you are more dead than alive we need you" and the importance of the human connection.

- Lital Mauda—Volunteer for 9 years. In the past year she has worked primarily with two projects: (1) Elderly new immigrants from Russia, especially in Kiriyat Shmona, in a community outreach format. (2) Coordinator of a support group for Ethiopian orphans raised by older siblings. Lital gave an example of an eighteen year old girl who lost both her parents and has taken the responsibility for her five younger siblings, with almost no resources.

- Orian Halili—A recently arrived social worker with a specialty in criminology.

- Dana Missulawin—a lawyer who works with special projects.

- Micah Feldmann—a renowned expert on Ethiopian Jewry who now heads the Ethiopian Division of Selah. Approximately thirty percent of new utilizers of services at Selah are Ethiopian.

- Aliza Dorani—A social worker who is coordinator of referrals from trauma specialists. Aliza is also responsible for vital data of recipients and their needs.

Shanee Hosdorf—Young volunteer who is doing her national service at Selah. She works with 6 immigrant families, both from Ethiopian and the FSU.

- Leah Blustein—has been with Selah from the start. She contacts the families, identifies needs and directs the volunteers.

- Limor Regev—runs the support groups and healing retreats, for example: bereaved families, grandparents raising orphaned grandchildren, older brothers raising orphaned siblings and battered immigrant women who left shelters for the abused without any community support. There are monthly programs and 2–3-day retreats once or twice a year.

- Chana Shimon—an Ethiopian young woman from Sderot whose home was almost destroyed by Kassam rockets, she is now doing her national service at Selah helping bereaved Ethiopian families.

- Dr. Eleanor Pardess—A clinical psychologist, she has been a volunteer at Selah and works with the first aid emergency response teams on how to reach difficult populations who are isolated and cut off from support systems. She also works with an interdisciplinary team facilitating a long-term Multidimensional Support Program. As part of this comprehensive support program, nature-based workshops are held in the context of 2–3-day retreats. Eleanor has conceptualized the model of support program named M.O.V.I.N.G. ENCOUNTERS. This model which has been developed over the past 15 years, combines nature excursions, outdoor physical activities and exploration of metaphors from nature, such as survival in the desert, rooting and grounding or the regeneration of burnt trees, with a variety of expressive arts.

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The concept of M.O.V.I.N.G. ENCOUNTERS highlights the idea of re-establishing the flow of life and of creating the conditions that may facilitate moving in relationship to oneself, others, and the world. The choice of the term captures multiple meanings, including:

The actual physical movement which is an important part of the seminar program incorporating the nature excursions, stretching and breathing exercises as well as relaxation techniques and possibilities of dance therapy or martial art therapies.

The word “motion” is directly related to emotion (Stern, 1984), so movement creates space for shared e-motion.

The concept of moving is also relevant as a natural antidote to the post-traumatic experience of being immobilized, blocked, frozen and stuck in time

Moving along together includes moving backwards (remembering) and forward, thus bridging continuity between past, present and future.

As an acronym the term M.O.V.I.N.G. designates the following components, dimensions which are conditions facilitative of posttraumatic growth:

M – Meaning reconstruction; **O** – Opportunities for sharing;
V – Validating grief; **I** – Involvement in creative activity;
N – Nature immersion; **G** – Group experiences fostering a sense of belonging and connectedness.

Natal: Israel Trauma Center for Victims of Terror and War

The founder of Natal came highly recommended by Lesley University, who knew her as a graduate of their Master’s program in Arts and Expressive Therapies, and spoke of her in hushed terms.

Judith Yovel Recanati, founder and chairperson of Natal, met me in her office in a modern building in the heart of Tel Aviv on July 20. Natal began in 1998, an optimistic period for Israel in which residents thought a new era of peace was around the corner. Natal was the brainchild of Dr. Yossi Hadar who envisioned Natal as taking care of trauma from the previous wars and terrorism. At that time, most of the country was in denial about trauma; soldiers either felt shame or guilt about needing help or were not even aware that they suffered or why. Natal was opened in June of 1998, but Dr. Yossi Hadar was diagnosed and died dramatically 2 weeks later of leukemia. Judith Yovel Recanati and some of the clinical team believed that addressing the ongoing reality of trauma directly was so important that they decided to continue the center and re-opened it in November 1998. She believed that Israel was founded out of heroic desire to counteract the stereotype of “the Jew as weak,” so that admitting vulnerability or psychological injury has been taboo. Judith Yovel is dedicated to opening the subject of trauma from its current place of denial into a realistic assessment and provision of necessary treatment. She believes that everyone in Israel lives with underlying existential trauma and should have a supportive environment

to deal with this trauma.

Natal’s mission statement states that Natal was “founded out of a deep identification with the distress of those who were psychologically injured directly or indirectly in Israel’s wars, terror attacks and other traumatic events resulting from the Israeli-Arab conflict. Its worldview sees National Psychotrauma as part of the existential reality of Israeli society. All are susceptible to trauma.”

Natal is a:

- Multidisciplinary treatment center for victims of terror and war related trauma dedicated to improve their quality of life;
- Training center for professionals and at-risk populations in preventing and coping with trauma;
- Educational resource center to promote knowledge and awareness about terror and war-related trauma in Israeli society.

Since that time, Natal has become a major therapeutic body in Israel. Natal added a Community Outreach Team with 15 professionals under the leadership of Dr. Rony Berger providing art therapy, biofeedback, and groups in three languages. Natal has been working daily in Sderot for the past 7 years and has a mobile unit that visits people who are afraid to leave their homes. More than 1,200 patients have already been treated this way. Most of the community outreach team work is actually done outside the Natal building.

In 2006 Natal started a project for the released combat soldiers after the second Lebanon War who reported nightmares, difficulty concentrating, difficulty in relationships, and use of drugs and alcohol. Natal now reaches out to soldiers either indirectly (by creating special events at Universities and showing a film about the Lebanon War and having a discussion group or by bringing a lecturer to talk about his own experience) or else directly (having programs on TV and on the radio). Newsletter inserts reach almost every home in Israel, and programs are held four times a year, including Yom Kippur, Memorial Day, and the anniversary of the Second Lebanon War. After 10 years, Judith Yovel Recanati sees a change—more people are seeing the possibility of getting help, perhaps preventing chronic trauma. Natal is now affiliated with Tel Aviv University’s Medical School, and professionals from the whole country now get top quality studies, supervision, and a diploma at the end of the year. The curriculum includes other short specific courses, such as how to work on a Crisis Hotline.

On a tour, I met the following staff and saw:

- Saar Uziely—head of the clinical unit, a psychologist who told me that what distinguished Natal was a belief that neither one model of trauma recovery nor 1 hour a week of psychotherapy was enough: Trauma was “all over the place.” Natal’s approach used combined treatments such as psychology and social rehabilitation; for example, if a combat soldier was suffering from trauma, his wife was also in a support group. There was an in-house psychiatrist, as well as biofeedback, “safe touch therapy” and psychoeducation about PTSD to families. There is no time limit on the interventions (“short term doesn’t always work”). Some patients are in therapy up to 5 or more years, but the

Ministry of Defense or National Security pays for only part of the treatment.

Referrals come from the Hotline, and Dr. Uziely decides whether the callers need an intake before referring them to treatment. He screens for severe psychiatric or personality disorders, even though some disorders show up later during psychotherapy. Natal doesn't treat soldiers while they are in the army, only after they have completed their tours of duty. At the time of discharge, each soldier gets an orientation and brochure about Natal, and Dr. Uziely coordinates therapists.

The tour included the newly renovated beautiful building in the center of Tel-Aviv. Each floor had its own kitchen, promoting a home-like feeling among staff and participants. The building was designed to create a feeling of a safe space—to be a container. Groups that were in session at the time included: stained glass (objects made in the workshop are sold in benefits for Natal therapeutic-social club), painting, and photography. Other groups offered Feldenkrais, computer, and music. The Hotline was made up of only about 5% psychotherapists; most volunteers are specially trained older members of the community with life experience who make real relationships with the Hotline callers, are called by their first names, and follow up personally on phone calls. They go through a six-month training and get supervision in cohort groups. Callers use an 1-800 number that is free to them. About 15 psychologists staff Natal, but about 70 more work in locations around the country and in their own clinics.

I came away very impressed with:

- The fierce passion of its founding members and the breadth of their vision;
- The skillful early interventions, such as handing out brochures to all soldiers on their last day, to prevent trauma from hardening into a chronic state;
- The diversity of their models and a conviction that no “one size fits all.” The clinic had services for individuals, couples, groups and families, children and families of soldiers, crisis interventions and ongoing groups. Natal is committed to a holistic model—using verbal and nonverbal therapies—growing from a strong therapeutic relationship.

Casualty Division of the Israeli Defense Forces (IDF)

In 2006, I was teaching a course called “Group Process Through Expressive Therapies” for Lesley University in Netanya. Just before I came to Israel, the Second War in Lebanon (see *The Use of the Arts to work with Trauma in Israel*) started. Many members of the class were gripped by their own experiences of trauma as their sons and husbands were called to the front.

In that class was student Ayala Katz. Her first husband had been killed 16 years previously during an army service. The group gave her, and others, an opportunity to feel and express their emotions and was so helpful that we both shared a dream of being able to offer this help to the soldiers who were then serving. Since Ayala had a long-standing relationship with the Casualty Division of the IDF, this was a way to give back to the caregivers. Our dream came true 2

years later, exactly on the 2-year anniversary of that war.

Ayala arranged a meeting with Sharon Gal, the Training Coordinator of the Casualty Department, and we planned a 1-day trauma workshop held on July 21, 2008.

IDF Casualty Division

I was impressed by the depth of caring shown by the outreach services of the Casualty Division. The Casualty Division had been in touch with Ayala like with other bereaved families, mothers and fathers, siblings, widows, and orphans. They help when an orphan or a bereaved sibling joins the army. They create trips and vacations for the families and help whenever they can.

Whole-Person Approaches to Working With Trauma

We met close to Tel-Aviv in the small town of Giva'taim, in the House of the Fallen Soldiers, donated by the house manager in honor of this workshop. Every town has one of these houses, dedicated to ongoing events and memorials for the soldiers and families of that town. Ayala had grown up in this town, and her grandfather's sculpture graced one of the rooms, donated even before her husband was killed.

Participants

Twelve group participants ages 19 to 22 had responded to a note from Sharon Gal offering a free workshop to help cope with stress. Ironically, the date was the 2nd year anniversary of the Second Lebanon War. So six participants were obligated to attend memorials and the remaining six participants attended the workshop. These girls were officers who chose to serve in the Casualty Division and were on call 24/7. Already in the army, they went to officer training school, and in addition volunteered to work with the Casualty Division. They visited soldiers with medical and psychological wounds in hospitals, visited their families, and dealt with bereavement and memorials. Most in this group were getting near the end of their service, having been caregivers for 1.5 to 2 years. They traveled the breadth of Israel alone to represent the Army. They encountered not only intense fears and grief, but also anger felt by many families at the Army. Clearly, some were very exhausted.

Sharon, a marriage and family therapist as well as an Army officer, conducted the pre-service screening. She monitors the group participants during their service, and offers a 2-hour support group every 2 weeks. This support group is led by an outside professional, but is limited to verbal psychotherapy. The women are encouraged to talk about everything, including whether they would stay in the Army or the Casualty Department. At the end of their service they have exit interviews, although they are not followed to see the effects of their stresses on them after service is over.

All participants are assigned randomly to units; one group member had been assigned to the tanks, another with the machines, one with the navy, and one as a back-up support system for the others.

Their most common issue was described as being one of “boundaries”: being able to say “no.” Many were young

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and idealistic, and still wanted to “save the world”—“they want to be angels.” All are single and live with their families, who do not meet regularly with the Casualty Department Training Coordinator.

During the lunch break, I had the opportunity to talk informally with some of the group participants. Roni described herself as in a support or managerial role, helping others plan their trips, but therefore lacking some of their “tools” for direct trauma work. When I asked her what drew her to this work, she said it was “to help our soldiers”—the “thanks from them motivates me.” She wanted to share with me “stories that really touched my heart, like the officer who lost both her legs” from a parachute jump. When she brought the Chief of Staff to help the soldiers light Chanukkah candles, her satisfaction was “to see their smiles and joy.” She had been on this job for 1 to 1.5 years, and was beginning “to withdraw” and “get ready to leave.” My motivation is “love and concern for the soldiers.”

When I asked her if she felt fear, she said: “Not really—sometimes I don’t know how to react.” What was difficult? “We have some families who are angry at the Army and they don’t know who to blame.” Other times, she said, however the families are “so happy” you are there. “Sometimes” she said, “this soldier (a female parachuter who lost both legs) so inspires me that I had energies for the whole week.” She saw herself as creating a way of life for those who have been hurt, and could answer her own question when she sees the suffering around her: “What can I do about it?” Roni also acknowledged having a great deal of fun with the soldiers, and learning about herself in the process. She said she “suddenly appreciated what she had,” and had a better sense of perspective in life.

Group Process

The group started with a warm up that provided a structured beginning to ease the anxieties of young women who are used to a very hierarchical and disciplined approach to life. We began with exercises that were familiar to them, and neutral in emotional content. We passed the leadership around the circle several times; each time, the women got a little looser, a little more expressive. The movement at this point was used to create a circle, to bring everyone together, to support and energize them.

We then drew self-portraits. My suggestion was simply “Draw yourself.” Several of the women drew surprisingly colorful and innocent-looking young girls with blond hair and very long/curly eyelashes. At this point they shared thoughts and discovered that some of them created the drawing with mostly the color of their army beret (IDF soldiers have different color berets, according to their unit). That was a meaningful discovery for them, as it was revealing their association, or attachment, to the unit to which they were assigned. Drawings of “flow” and “flower” were present. As the group went on, they got progressively more playful, as though the opportunities to be giggling young women really were emerging. They seemed hungry for the chance to be youthful, carefree and play: Roni said

“this is a great way to deal with things we have to deal with every day.” She described her drawing as “free.” Even though she too was struggling with the issue of whether or not to continue with the army, she was also in touch with her “big dreams” and understood that she was free because “I decide.”

Shoshi’s first drawing had “heavy bricks” that reminded her that she “can’t be free,” but her in her second drawing “a lot of things went out.” It was a “pure feeling.”

One whose drawing was entitled “Flow” said: “My way to life is to being happy,” with “light” and “friendship.” One whose drawing was called “Flower” said: “my heart is a big flower.”

In Nurit’s drawing, a “moment of breath” was in the center circle, but “you can see the cell phones...we can’t really detach ourselves from the job.”

A young officer who left her parents behind when she came to Israel drew a picture of herself as a small girl in bed with a window showing the night sky above her. She said that sometimes she “feels like a little kid.” Sometimes she “feels like she wants to be back to kindergarten.” The light blue clouds in her drawing symbolized “the good things in life,” and dark blue the “difficult things in life.”

The short meditation brought up a great deal of sadness, together with feelings of love and togetherness. A few said to me, trying to explain: “We don’t even have 20 minutes to rest during a normal day at work.” One shared her guilt at sleeping through a crisis phone call one night. Another said that she might not want to continue volunteering: “It is too hard to live like this.” Cell phones were vibrating throughout the meditation time, more noticeable than during other parts of the day.

We then moved into a lighter, more energized mode with Caribbean dancing, use of scarves, and improvisation. While they still preferred a structured circle form, they also moved into dyads, lines, and other forms. They were happy and playful, and then we did drawing #2.

They said the group had given them a chance to feel their feelings, while overall strengthening, resting and refreshing themselves. It gave them a chance to play and live in their imaginations. They want to continue this kind of work. They also expressed their contentment from knowing each other better, and for the opportunity just to be with what they have and with whom they serve. Many said they realized during the workshop how their hobbies are important in their lives. They used to dance, draw, do sports and now they miss those hobbies, while their army duty takes almost every minute of their time.

Having Ayala co-lead the group with me added a valuable new dimension to the group. She made a bridge, letting the group know that she had her own experience with the Casualty Division and acting as an interpreter. She also brought her own experience of the army and Israeli society to the group, and added her reflections. She said:

One thing that comes back to me is the fact that they almost didn’t talk or expressed the difficulties of meeting wounded soldiers or bereaved families. They did talk about not having time for themselves, they did say that they are tired, they did talk about their personal future and whether to stay in the army or not (most of them has at least a year to

serve). Maybe this happened because we focused on them, told them that it is time that they can take for themselves or was it something else, like a need for more trust or security with us and among themselves. Or, it is maybe something with the current Israeli society, a more personal than collective culture.

The other thing was the closeness, the togetherness, that was built during the day, out of moving and sharing music together. For me it is a miracle every time I encounter this phenomenon.

With all the issues that were in this room, I felt like I was forgetting myself, but very connected to myself. I could feel the many people that come to this specific house every year in Memorial Day Eve to honor the fallen soldiers; that walk around to look at the names; that stands still with the whole country for 2 minutes when the sirens are on, in front of the house, where the Israeli flag is up on the flagpole (where the group took pictures at the end of the day). It was as if there was a huge backup to be there for these young officers. I wanted so much to empower them, to tell them how their job is so important to so many people, so helpful, so meaningful and significant. Maybe by helping to create this day for them I actually said it ...

Maybe the biggest thing for me was the realization that dreams come true, with hard work and a lot of patience, when it is the right time and place ... If we don't dream, things will not happen. For me it was an extraordinary event.

After sharing their drawings, and closed the workshop, the young women got back into their uniforms, getting ready to go back, some to work, and some back home. The group took photos together in their uniforms and expressed warmth and support to each other. It took them some time to leave the place, to say goodbye.

Conclusion

In the case of human suffering, we are all brothers and sisters. Soldiers and their families in Israel and in the United States can learn from each others' experiences. It is hoped that this report will be one step toward addressing these shared human traumas through collaboration.

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What Juries Don't Know: Dissemination of Research on Victim Response is Essential for Justice

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I recently served as an expert witness for the prosecution in a federal criminal case. It was a new and eye-opening experience for me. I was asked to educate the jury about what we know from research about victim response to sexual assault. It became clear to me that I was only needed because of widespread ignorance about the reality of sexual assault in the general public, and thus in the population of potential jurors. The experience was a stark reminder of the importance of research dissemination and education on societal and criminal justice. Our research can only have an impact if it reaches the right people. In the case of a jury trial the right people are the jurors.

Jurors are asked to rely on their common sense and reason. This works well when common sense and reason coincide with empirical reality. However, the criminal justice system is at risk if jurors show pervasive ignorance or, worse, adherence to dangerous myths. Rather than holding accurate knowledge of victim psychology, many individuals endorse some degree of belief in what researchers have called "rape myths" and "child sexual abuse myths" (Burt, 1980; Collings, 1997; Cromer & Freyd, 2007; Cromer, in press). These myths can work against justice in profound ways. Educating the

public about victim response to sexual assault so that jurors can rely on their common sense is thus a crucial duty for trauma researchers and educators.

The criminal case for which I recently served as an expert witness involved abusive sexual contact aboard an aircraft. The victim was at the time a 16-year-old girl and the defendant was her 32-year-old coach. The case was federal because the offense occurred on an airplane.

The defendant admitted to FBI investigators that the sexual acts did occur. There was no prior romance, flirtation, or invitation between coach and athlete. They were returning from an athletic event. The victim had fallen asleep under a blanket in the window seat and the defendant was seated next to her. It was nighttime and dark in the plane. She woke up to him touching her under her clothing. The victim displayed a fairly passive or "frozen" response to finding herself in this predicament.

The age of consent in federal sexual assault cases is 16. The defense attempted to portray the events as consensual sex, relying heavily on the implicit question: If she didn't want the sexual intrusion why didn't she actively object? The defense attorney in closing arguments suggested that the victim and her coach had together created a "bubble of intimacy" on that plane that



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was later burst causing the victim to feel “sexual regret” and claim the sexual acts were without her permission.

In my testimony I had drawn on research about victims to educate the jury that a passive response to sexual assault is not uncommon and I discussed some of the research regarding factors that are associated with such a response, such as fear and perceived powerlessness. During closing arguments, the prosecutor was able to remind the jury that crime victims often do respond passively and to remind the jury of all the substantial evidence contrary to the defense argument of consent. The jury found the defendant guilty.

Consent in sexual assault cases remains a vexed issue in American courts. In the excellent book, *Unwanted Sex: The Culture of Intimidation and the Failure of Law*, Stephen Schulhofer (1998), traces the history of consent laws. He notes that in the sixteenth century “the common law of theft protected an owner’s property only when a wrongdoer physically removed it from the owner’s possession, against the will and by force. . .” (p. 3). However “the law evolved, slowly at first, to fill the intolerable gaps,” (p. 3). Today the law “punishes virtually all interference with property rights without the owner’s genuine consent. Yet there has been no comparable evolution and modernization of the law of sexual assault.” (p. 4). In other words, if your front door is unlocked and someone you know walks into your house and takes your laptop computer while you cower in the corner, this is a crime unless you have explicitly given affirmative permission. There is no argument to be made that you have implicitly consented to engage in giving away your possessions by your open door, the prior display of your product, or your silence during the theft. Compare this state of affairs to current beliefs about sexual assault where victims can be blamed for their clothing and are often held responsible for providing active resistance. Furthermore, sexual assault law currently draws inconsistent lines regarding age of consent, and is largely insensitive to other aspects of power differential (such as formal roles of authority and power) that can vastly reduce a person’s ability to freely consent.

The combination of insufficient legal clarity about the standards for consent with wide-spread ignorance about victim response opens the door for a defense that blames the victim and potentially holds her responsible for sexual assault while leaving the perpetrator not accountable. It is thus critical for justice that we do even more to educate the public.

Below I offer a list of some of the things we know from research in trauma psychology (and associated references) that are likely not sufficiently known by potential jurors. We need to provide more education about these findings and also evaluate and monitor public understanding of these topics.

1. Passivity during sexual assault is a common response of both child and adult victims.

Studies suggest that anywhere from 1/3 of adult rape survivors (Burgess & Holmstrom, 1976) to 1/2 of child sexual abuse survivors (Heidt, Marx, & Forsyth, 2004) display a passive, even frozen, response during the assault. Naturally, people do wonder why and how this passive response occurs,

but it is important to recognize that separate from questions of motivation and mechanism we know from empirical scientific research on sexual victimization that such a passive response is quite common (Marx, Forsyth, & Lexington, 2008; Rizvi, Kaysen, Gutner, Griffin & Resick, 2008). There are research studies attempting to answer the “why” and “how” questions regarding victim passivity. It appears that there are a number of factors (such as power disparity) and pathways that are associated with a passive response ranging from a conscious decision based on the assessment that it is a wise course of action given the dangers of resisting, to involuntary mental processes such as dissociation and involuntary physiological responses of paralysis or freezing. In the scientific literature on sexual assault this constellation of victim passive/freeze responses is sometimes called “rape induced paralysis” and increasingly often called “tonic immobility” although there is also a more technical use of that term (Marx, Forsyth, & Lexington, 2008).

2. Sometimes victims forget all or part of their assault experience.

Numerous studies have shown that some percentage of trauma victims either display or later report a period of forgetting the event (Elliott, 1997; Sivers, Schooler, & Freyd, 2001; Williams, 1995). Forgetting can occur even after a period of remembering the event (Schooler, 2001). Elliott (1997) investigated memory for a wide range of traumatic experiences in a carefully executed research study using a representative sample of Americans. Elliott reported that overall across different types of trauma 17% reported partial forgetting and 15% a period of complete memory loss (for a total of 32% reporting delayed recall) for various traumatic experiences. Rates of forgetting were higher for certain interpersonal victimization experiences (such as childhood abuse and completed rape) and lower for certain non-interpersonal traumas (such as motor vehicle accidents). Forgetting is apparently more likely in cases involving a betrayal trauma such as when the victim trusted, was very close to, and/or was dependent upon the perpetrator (Freyd, 1996; Freyd, DePrince, & Zurbriggen, 2001).

3. Often victims do not disclose the assault at all or disclose only after a delay. Sometimes victims retract a legitimate accusation.

Numerous studies have discovered that non-disclosure, recanting, and delayed disclosure to be common occurrences for sexual assault (Bolen & Scannapieco, 1999; DeVoe & Faller, 1999; Fergusson, Horwood, & Woodward, 2000; Ullman & Filipas, 2003). Most of those who experience child sexual assault do not disclose until adulthood and many never tell at all (Jonzon & Lindblad, 2004; Smith et al., 2000). Studies have also revealed a pattern of recanting and redisclosure (Elliott & Briere, 1994; Sorenson & Snow, 1991). Non-disclosure, delayed disclosure, and retraction are particularly likely in cases in which the perpetrator is close to the victim (Lyon, 2007; Malloy, Lyon, & Quas, 2007; Tang, Freyd, & Wang, 2007).

4. Assault by a familiar other is both more common and potentially more toxic than assault by a stranger.

Most sexual assault is committed by individuals known to the victim, which increases the likelihood of delayed

disclosure, unsupportive reactions, and worse outcomes (Freyd, Klest, & Allard, 2005; Freyd, Putnam, et al, 2005;; Russell, 1994). Widely held stereotypes about “stranger danger” seem to be particularly confused about the relative risk of assault by someone known to the victim and about the relative harm of assault by such a perpetrator. For instance, if a girl was on a plane next to a man she didn’t know and she fell asleep and woke up to him touching her and explained she felt too scared to do anything, would the defense attempt a consent defense? Would it have a chance with a jury? My intuition is no, that this defense only has a chance because they were acquainted. What is it about the fact that a victim knew a perpetrator that potentially opens the consent door despite no prior invitation? Perhaps there are a number of beliefs that people hold about women in relation to sexual assault: for example, that females enjoy being sexually touched by familiar men simply because they are familiar, and/or that they have more freedom to object to unwanted touch by familiar men, and/or that men have implicit rights to touch females they know. None of these ideas are at all correct. Women or girls assaulted by someone known to them are at heightened risk for non disclosure and negative outcome.

5. Victims often display a constellation of reactions after the assault including avoidance of social contact and a drive to shower at even the thought of the event.

Responses to adult sexual assault and child sexual abuse are diverse. Some individuals display great distress whereas others do not. Immediate reactions are likely to include fear, anxiety, confusion, and social withdrawal (Herman, 1992). Victims often report not wanting to be seen by others as well as a desire to shower or cleanse themselves repeatedly for days to months after the assault (see Frieze, Hymer, & Greenberg, 1987; Herba & Rachman, 2007; Koss, 1993; Rizvi et al, 2008; Russell, 1975). Long term, these crimes increase the risk of a host of negative outcomes including PTSD, depression, suicide, and other mental health problems (Yuan, Koss, & Stone, 2006).

6. Disbelieving and blaming the victim can compound the damage done by the assault.

Negative reactions to disclosure, particularly disbelieving and blaming the victim, can be particularly damaging to the well-being of victims of sexual assault (Ullman & Filipas, 2005). As Marx explained: “In our society, the validity of reports of sexual violence is often questioned, and survivors are blamed for their sexual assaults. Furthermore, the consequences of these experiences are often trivialized or ignored by family, friends, police, legal officials, and sometimes even mental health professionals. Unfortunately, such social conditions further create stigma and shame for survivors, thereby compounding the destructiveness of their experiences.” (2005, p. 226).

This list of relevant research findings not generally known by the public is far from exhaustive. There is much more we know about trauma psychology in general and the response of victims to sexual assault in particular. If the public and thus potential jurors were better educated prior to serving on a case, expert testimony such as mine would not be needed. An educated public would lead to a better world

for both the criminal justice system and society more widely. An educated public would make it more likely that eventually the laws themselves would be improved to better reflect the reality of power dynamics and victim response. An educated public would better defend our freedom from assault. The results of our research are often highly relevant to making fair and good decisions about the treatment, prevention, and responsibility for interpersonal violations. Knowledge of that research is also often highly relevant to how helpfully and effectively we interact with each other in society. May our efforts in research and research dissemination intensify and flourish.

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Partnering with Community- and System-Based Agencies Dealing With Trauma to Bring Service Learning to Psychology Courses

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How can the resources of the university be mobilized to contribute in meaningful ways to agencies dealing with trauma and violence in the community while simultaneously pursuing student learning objectives in traditional psychology classes, such as Research Methods? Here we share an outline of how we incorporated service-learning into a Research Methods class through partnerships with three community-based agencies dealing with trauma and violence.

In many undergraduate programs, Research Methods (or some variation on the theme) is a required course for undergraduate psychology majors/minors. Anecdotal reports are common of students' lack of enthusiasm, if not outright distaste, for their required Research Methods classes. Many students have shared with us the belief that Research Methods just isn't relevant to their lives because, for example, their career

goals focus on more applied clinical work; or that they will never do research, so should not have to spend a class on those skills.

Not surprisingly, our perceptions differed from the students'. We see Research Methods as a potentially invaluable course for teaching critical thinking skills that can be applied to numerous situations and professions. We also see that Research Methods can help students become better consumers of research, even if they never planned to create their own research. But, the choruses of "how does this apply to my career goals, life" encouraged us to look for ways to better connect learning with the community in which students were situated.

Service learning seemed like an ideal way to show students that research skills are relevant to answering important, applied questions faced by our community. Further, service learning provided us with a way to mobilize the educational resources of the university to support agencies dealing with trauma and violence in our community. Working together as Instructor



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(AD) and Teaching Assistant (SP) in 2008, we created and implemented a service-learning component for our research methods class that was designed to support students' learning and connect the resources of the university with a community-defined need.

Our first implementation of a service-learning component occurred during Winter Quarter (2008). Our Research Methods class partnered with the WINGS Foundation (WINGS; <http://www.wingsfound.org/>), a non-profit that provides resources to adult survivors of childhood sexual abuse. In preparation for the class, DePrince talked with the Executive Director of WINGS, Anne Guarnera, about the agency's research needs. Guarnera explained that the agency had years of intake data from initial phone contacts with potential clients, but neither knew how nor had time to analyze the data. Guarnera believed that the data, if analyzed, would help the agency better understand the needs of their clients.

At the start of the quarter, Guarnera came to talk with our class about the WINGS program, clients, and research questions. She described the database that the agency had created over the years. Copies of the intake interview were then made available to students. Using the intake interviews as a guide for the range of possible variables to be examined, students completed the following tasks across four paper assignments: conducted a background literature review, identified a research question(s) that involved variables for which we had data, articulated directional hypotheses, and identified analyses to test the hypotheses. We worked closely with students at all stages, but particularly to help them identify appropriate analyses to test their hypotheses.

On our end, we spent significant time preparing the dataset for students' analyses, including coding variables and cleaning up Access data for SPSS. Based on the analyses student proposed to test their hypotheses, we actually conducted the analyses for students so that the dataset was not released publicly. We emailed students the relevant output from their analyses, at which point they began writing up Results and Discussion sections.

Students turned in one section of the paper at a time across the quarter and received extensive feedback. For their final paper, each student revised their earlier assignments to submit a complete APA manuscript, including Introduction and Discussion sections that placed the analyses of the WINGS database in the context of the larger empirical literature on adult survivors. Under our close supervision (and with student permission), the top 4 papers were submitted to our community partner. After reviewing the top manuscripts, Guarnera reported, "We're very grateful to the research methods class...for realizing the research value in what we do every day...The results and papers are going to help us in targeting our outreach and making sure that our program is relevant to the issues survivors of childhood sexual abuse are experiencing."

During the Spring Quarter (2008), we partnered with two organizations: SafeHouse Denver and the Denver District Attorney's Office. Both partners had research questions related to domestic violence and were interested in proposals for appropriate methods to answer those questions. After hearing presentations from both partners, students picked a partner. They then spent the quarter developing proposals to answer the research questions identified by our partners. As in the previous class, they developed all of the sections of an APA manuscript, detailing how they recommended the partners go about doing the research that would answer their questions. For the Results section, students proposed analyses for their specific research design. Discussion sections focused on identifying the relative strengths and limitations of their designs as well as the context for how this research fit into the goals of our partners and the larger field. At the end of

the quarter, we invited our partners to return to the class to hear brief presentations on the student proposals. This capstone experience gave the students and partners an opportunity to dialogue about the proposals. Finally, we submitted the top manuscripts (with student permission) to our partners.

Our hope is that these real-world exercises demonstrated to students that the skills they acquire in Research Methods are applicable to important social issues, such as trauma and violence. Further, we hope that the structure of the class tapped the power that service-learning courses can have: that students can meet learning objectives (in this case to develop basic research methods and critical analysis skills) while engaging in service in their community. We believe that these collaborations with community partners gave students a unique, hands-on opportunity to learn about design principles. For example, the classes learned to evaluate questions such as: 1.) given certain non-experimental designs, what inferences can and cannot be made about causal relationships; and 2.) given certain relationships between psychological variables in a treatment-seeking population, what can we generalize to non-treatment seeking populations?

During Spring Quarter, we asked students to write for one-minute on (and anonymously submit) their thoughts about the service-learning project. The enthusiasm and passion described in their statements was notable. A common sentiment was expressed by one student: "I liked that we were able to work on a project that had a real-world application. This...enforced the need/rekindled the desire to do proper methods and really search for something that would make a good end product! I loved this assignment compared to other search projects in psychology classes and it really drilled in the method of scientific research procedures."



Sarah Priebe, MA

Chronic Pain in Adult Survivors of Childhood Abuse

Kathleen Kendall-Tackett, PhD

Chronic pain is a common symptom in patients in general—and even more common in adult survivors of childhood abuse. But patients rarely reveal their abuse history to their care providers. And even when survivors do, health care providers rarely connect events in childhood to symptoms in adults.

In this article, I describe challenges for providers in understanding and diagnosing chronic pain. I also describe two common pain syndromes that have been associated with past abuse—fibromyalgia and irritable bowel syndrome—and possible mechanisms by which traumatic events can lead to chronic pain, including changes in neurotransmitter levels and sleep architecture. Finally, I describe some preliminary interventions that are possible with adult survivors who are now suffering from chronic pain.



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The Challenges of Chronic Pain

To practitioners, chronic pain is a diagnostic enigma. The amount of pain chronic-pain patients report often seems far above what doctors would expect, especially when there are no lab or radiologic findings to confirm its existence. Not surprisingly, doctors often become frustrated with chronic pain patients, as Gershon (1998) notes.

Physicians become angry. Patients who present themselves to doctors with problems that are insolvable are perceived as threatening and are often dismissed as mentally unbalanced, with the epithet “crocks” whispered behind their backs (p. xiv).

There are several aspects of chronic pain that make it difficult to treat. First, pain is subjective, and people are often upset when they talk about it. Therefore, it is difficult for an outsider to step into the patient’s shoes and understand his experience. Second, chronic pain does not fit classic models of disease that says that pain is due to tissue damage. In many cases, there is little or no verifiable physical evidence to support a patient’s story. Finally, chronic pain results from a complicated interaction of psychological, social and physical factors including past and present experiences, socioeconomic status, social support, personal values, and ethnic background (with some ethnic groups tending to be more “stoic” about pain than others). All of these factors make chronic pain difficult to understand and treat. Add to it a history of childhood abuse, and it further complicates the picture.

In the next section, I examine the connection between past abuse and chronic pain. But first, a few general concepts.

Pain Threshold, Secondary Hyperalgesia, and Central Sensitization

Some people have a higher tolerance for pain than others. In making these comparisons, we speak of the pain threshold. Threshold refers to the magnitude of sensation necessary for it to be perceived. Someone with a lower pain threshold is hypersensitive, and will perceive pain even when lightly touched. Some consider this hypersensitivity a major evolutionary advantage because it alerts people to potential danger. However, the increased pain when not in danger makes for a poor tradeoff (Woolf & Salter, 2000).

Another way to describe the lowered pain threshold is secondary hyperalgesia. In primary hyperalgesia, pain perception stems directly from pain caused by damaged tissue. In secondary hyperalgesia, pain exists without injured tissues; even light touches are perceived as painful.

Prolonged sensory disturbance reduces the pain threshold, and the net result is that the neurons fire at low levels.

Central sensitization is another key concept. It is responsible for hypersensitivity spreading to non-injured tissue (Crofford, 2007; Marcus, 2000; Woolf & Salter, 2000). Central sensitization explains why pain that starts in one specific area of the body can “spread” to other areas—even when there has been no tissue damage in that area (Miller, 2000).

In the next section, I describe two pain syndromes that have been associated with childhood abuse. Secondary hyperalgesia, lowered pain thresholds, and central sensitization will be revisited when describing these specific conditions as well.

Chronic Pain Syndromes in Adult Survivors

In this section, I describe research on the relationship between childhood abuse and two chronic pain syndromes: fibromyalgia, and irritable bowel syndrome. Their pathophysiology are also described.

Fibromyalgia Syndrome

Fibromyalgia syndrome (FMS) is chronic pain syndrome characterized by widespread musculoskeletal pain, decreased pain threshold, sleep disturbance and psychological distress (Boisset-Pioro, Esdaile, & Fitzcharles, 1995; Crofford, 2007; Wolfe, 1997). FMS is diagnosed using American College of Rheumatology (ACR) criteria. FMS includes widespread pain that persists for at least three months, and tenderness in at least 11 of 18 specific tender points (Bradley & Alarcon, 1997).

Three studies have examined whether past abuse is more common in patients with FMS. In one study, 40 women with FMS were compared to 42 healthy women (Taylor, Trotter, & Csuka, 1995). Sixty-five percent of women with FMS reported a history of sexual abuse, compared with 52% of the controls.¹ The difference between the groups was not significant. Abuse history was related to a more severe

manifestation of symptoms and greater functional disability, however. Within the patient group, sexually abused FMS patients reported significantly more symptoms and pain than did non-abused FMS patients. Sexual abuse appeared to exacerbate the underlying condition (Taylor et al., 1995).

Another study (Boisset-Pioro, et al., 1995) compared 83 FMS patients with 161 arthritis patients with no FMS. Fifty-three percent of the FMS patients reported a history of physical or sexual abuse, compared with 42% of non-FMS patients, with no significant difference. FMS patients who were sexually abused in childhood had significantly more symptoms than non-FMS patients. This was especially true if the abuse was contact abuse, or if there were multiple events. In addition, FMS patients were significantly more likely to report physical abuse in child- or adulthood, or in combination with sexual abuse, than the non-FMS patients.

McBeth and colleagues (McBeth, MacFarlane, Benjamin, Morris, & Silman, 1999) with a community sample indicated that subjects who experienced childhood adversity (child abuse, parental loss, illness of a family member, and parental drug overdose) had a significantly higher tender point count than subjects without this history. The odds ratio for child abuse was particularly high (OR = 6.9), and indeed childhood abuse was the best independent predictor of a high tender-point count.

More recently, Sachs-Ericsson and colleagues (Sachs-Ericsson, Kendall-Tackett, & Hernandez, 2007), using data from the National Comorbidity Study, noted that subjects with a history of either physical or sexual child abuse, or intimate partner violence, were more likely to report pain when describing their current health symptoms. Van Houdenhove et al. (in press) found that 64% of patients in a group for FMS or Chronic Fatigue Syndrome had at least one type of either child or adult trauma. More concerning was that 39% of the group reported abuse during childhood and as adults, indicating a lifelong pattern of abuse.

Although these findings are somewhat mixed, it does appear that childhood abuse can make men and women vulnerable to FMS. Research on the pathophysiology of FMS can provide insights about why this may occur.

The Pathophysiology of Fibromyalgia. At this point, no one knows what causes FMS. One theory is that prolonged emotional stress, infection or physical trauma combine with a genetic predisposition to make people sick (Bradley & Alarcon, 1997). This theory has inherent appeal. Many FMS sufferers can point to a specific traumatic event (e.g., a car accident, an infection, or a severe life stress) as the precipitant of their illness.

Neurotransmitter abnormalities have also been observed in FMS patients, such as dysregulation of the Autonomic Nervous System or HPA axis (Crofford, 2007). For example, Wolfe and colleagues noted that patients with FMS have low levels of serotonin and 5-HIAA (a serotonin metabolite) in their cerebral spinal fluid (Wolfe, Russell, Vipraio, Ross, & Anderson, 1997). Serotonin levels were significantly related to both depression and tender-point count.

FMS patients also have higher levels of the neuropeptide Substance P. In a study of 32 FMS patients and 30 healthy controls, those with FMS had 3 times more Substance P in their cerebral spinal fluid than the healthy controls (Russell et al., 1994). Serotonin controls Substance P, and when it is low, Substance P levels are allowed to rise (Wallace & Wallace, 2002).

Women with fibromyalgia also had abnormalities in their patterns of blood flow to parts of the brain associated with pain perception (Mountz, Bradley, Modell, Alexander, Triana-Alexander, Aaron, et al. 1995). As predicted, women with fibromyalgia had significantly impaired blood flow to three brain structures: the hemithalami, head of the caudate nucleus, and the cortex. Not surprisingly, these women's pain thresholds were significantly lower. Traumatic events may be behind these aberrant activation patterns, and the abnormal levels of serotonin and Substance P.

Sleep Problems in Fibromyalgia. Sleep is an area of interest in fibromyalgia research. In patients with FMS, deep, delta-stage sleep is interrupted by faster alpha waves that are superimposed on the delta sleep (Wallace & Wallace, 2002). A recent study examined these abnormalities in greater detail. Roizenblatt and colleagues (Roizenblatt, Moldofsky, Benedito-Silva, & Tufik, 2001) compared the sleep of 40 FMS patients and 43 healthy controls. They found three distinct patterns of alpha-wave activity in sleep. The first was *phasic alpha*, in which there is an episodic occurrence of alpha waves during delta activity. The second is *tonic alpha sleep*, where alpha is continuously present during non-REM sleep, not only during delta sleep. The third pattern is *low alpha* activity.

Phasic-alpha occurred in 50% of the FMS patients, and was the most common pattern for this group. It occurred in only 7% of the controls. In contrast, the low-alpha pattern was the most common for the controls (83%), compared to 30% of FMS patients. The phasic-alpha pattern was associated with longer-lasting pain symptoms and poor sleep quality. The patients with phasic-alpha sleep exhibited less total sleep time than the other two groups. Phasic-alpha sleep was associated with more pain, a higher tender-point count, and a greater number of clinical manifestations of FMS (Roizenblatt et al., 2001). Traumatic events may create changes in sleep such that abuse survivors manifest more phasic-alpha sleep.

Irritable Bowel Syndrome (IBS)

Irritable bowel syndrome is the second pain syndrome I describe. IBS is a functional disorder of the lower gastrointestinal tract. It is diagnosed using the "Rome criteria." Symptoms include abdominal pain or cramping; altered bowel habits (either diarrhea or constipation), consistency or passage; passage of mucus; and bloating or abdominal distention. The symptoms can be continuous or recurrent, and must be present for at least three months (American Gastroenterological Association, 1997). Symptoms generally present with one of two patterns: diarrhea without abdominal pain and

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alternating diarrhea and constipation with abdominal pain (Subramani & Janowitz, 1991). Not surprisingly, a relatively high percentage of people with IBS have a history of either physical or sexual abuse. As Leserman and Drossman (2007) note, patients with a history of physical or sexual abuse in childhood, or intimate partner violence, have 1.5 to 2 times the risk of reporting gastrointestinal symptoms or having a functional gastrointestinal disorder.

Walker and colleagues (1993) compared 28 patients with irritable bowel syndrome and 19 patients with inflammatory bowel disease (IBD). Sexual victimization was much more common among the IBS patients than those with IBD. Patients with IBS had higher rates of severe lifetime sexual trauma (32% vs. 0%), severe child sexual abuse (11% vs. 0%), and any lifetime sexual victimization (54% vs. 5%). When patients had co-occurring chronic pelvic pain, they were more distressed and had more functional disability than women who had either complaint alone.

IBS, heartburn, and upper-GI pain have been significantly related to all types of childhood and adult abuse in another study. Abused patients were twice as likely to have IBS as those who were not abused. Patients who reported abuse both in adulthood and childhood were three times as likely to have IBS. Although 40% of patients with a peptic ulcer had a history of abuse, the odds of having an ulcer were not significantly different based on abuse status (Talley, Fett, Zinsmeister, & Melton, 1994).

Ali and colleagues (Ali et al., 2000) found that women with functional GI illness (such as IBS) were significantly more likely to have been raped than women with organic GI illness (34% vs. 10%). Similarly, physical assault was more common in women with functional illness than in women with organic illness (18% vs. 10%).

Drossman and colleagues (Drossman, Li, Leserman, Toomey, & Hu, 1996; Leserman et al., 1996) found that 60% of women in treatment for GI illness had a history of abuse. Sixty-six percent of women with functional diagnoses, and 56% of women with organic conditions had abuse histories. This was an only marginally significant difference. The patients with histories of severe abuse (i.e., rape, life-threatening injuries) had more functional than organic illness. The functional conditions included esophageal pain, dyspepsia (upper abdominal pain), and IBS. The organic illnesses included ulcerative colitis, Crohn's disease, liver disease, pancreatic/biliary disease, and "other" organic disease. Interestingly, the highest percentages for abuse survivors were for functional abdominal pain (84%) and liver disease (72%). Liver disease included cirrhosis and chronic hepatitis B and C. These disorders could be a result of high-risk health behaviors (alcohol abuse, unsafe sex, sharing needles), and could explain why there is a high percentage of abuse survivors in this group.

In another study, Drossman, Leserman and colleagues (Drossman, Leserman, Li, Keefe, Hu, & Toomey, 2000) followed a group of 174 women who had been referred to a GI clinic for a period of 12 months. Half of their subjects had been physically or sexually abused, and 14% had experienced

severe abuse. Patients who were more severely abused also had poor health status. Patients who were "profoundly pessimistic" about their illnesses had poorer outcomes. Abuse and maladaptive coping were the two most important predictors of health outcome.

Scarinci and colleagues (Scarinci et al., 1994) studied a sample of 50 patients with 1 of 3 pain syndromes: gastroesophageal reflux disease (GERD), non-cardiac chest pain (NCCP), and irritable bowel syndrome (IBS). Fifty-six percent of the sample reported a history of physical or sexual abuse. Among the conditions studied, 92% of patients with GERD and 82% of patients with IBS were abuse survivors, compared with only 27% of patients with NCCP. Abused patients also had significantly lower pain threshold levels in response to finger pressure, and significantly lower cognitive standards for judging stimuli as noxious. These results held even after controlling for psychiatric disturbance.

Two Theories of Irritable Bowel Syndrome. There are no obvious physiological markers of IBS. However, as with FMS, some intriguing neuroendocrine and cerebral abnormalities have been observed. These studies are summarized below.

Changes in GI Physiology. One theory of IBS is that traumatic events lower the pain threshold of the viscera, making it hypersensitive to stimuli (Drossman, 1994; Wingate, 1991). There is preliminary empirical support for this view. In a study of pain perception, 14 IBS patients were compared to 11 healthy controls. After being exposed to high-pressure pain in the sigmoid colon, all of the IBS patients developed rectal hyperalgesia, whereas none of the control patients did. The IBS patients also showed signs of central sensitization—the pain "spread" to other parts of the abdomen, and outlasted the actual application of the stimulus (Munakata, Naliboff, Harraf, Kodner, Lembo, Chang, et al., 1997).

Hypersensitivity also can be measured in the brain. In this study using positron emission tomography (PET) scans, six IBS patients were compared with six healthy controls in their cerebral blood flow patterns following administration of painful stimuli (Silverman, Munakata, Ennes, Mandelkern, Hoh, & Mayer, 1997). Following the painful stimuli, the healthy subjects had activity in the anterior cingulate cortex. The patients with IBS, on the other hand, had activation of the left prefrontal cortex, and no activity in the anterior cingulate cortex (ACC).

The ACC releases endorphins and is part of a central nervous system response to pain (Toner, Segal, Emmott, & Myran, 2000). If the ACC does not respond, the pain modulation system fails and patients are more susceptible to pain. The prefrontal cortex is associated with both hypervigilance and anxiety. When it is activated, there is an increase in pain (Silverman et al., 1997; Toner et al., 2000). Cognitive-behavioral therapy may increase activation of the ACC, and decrease activation in the prefrontal cortex.

Enteric Nervous System. Research on the enteric nervous system also provides some insight into IBS. According to Gershon (1998), humans have three nervous systems: sympathetic, parasympathetic, and enteric. The enteric nervous system includes the nerve cells of the entire gut (esophagus, stomach, small and large intestine).

Gershon's research demonstrates that the enteric nervous system is distinct and large. The gut actually has *more* nerve cells than the spinal cord. The enteric nervous system can act independently of the other nervous systems, and can activate effectors all by itself. Serotonin is also manufactured and stored in the bowel, and is preferentially located on enteric nerves (Gershon, 1998).

This line of research raises some intriguing possibilities relevant to abuse survivors. Namely, do traumatic events influence this nervous system? Serotonin is one possible connection. Earlier, I referenced research on fibromyalgia that found abnormally low levels of serotonin related to sleep and pain difficulties. What is the relationship between trauma and levels of serotonin in the gut? How is the sensation of pain in the gut influenced by changes in serotonin levels? What is the relationship between the enteric nervous system and the central nervous system? Given what we know about visceral hypersensitivity, these questions should be considered in future research.

Conclusions about Pain and Abuse, So Far

So bringing all the evidence together, what have we learned? At this point, it appears that pain is somewhat more common in abuse survivors than in the general population. We also know that approximately half of all pain patients have a history of physical or sexual abuse. Some other general statements can be made.

Pain Symptoms Co-Occur

Researchers found that different types of pain often co-occur. These researchers generally focused on only one type of pain at the beginning of their studies. But the authors invariably found other types as well. For example, one study found that 70% of the FMS patients also had IBS, and 65% of the IBS patients had FMS compared with 12% of controls (Veale, Kavanagh, Fielding, & Fitzgerald, 1991). Sufferers of both syndromes also have other types of pain, including headache, backache, or pelvic pain.

Golding (1994) found those with a lifetime history of sexual assault were significantly more likely to report a wide range of chronic pain, and it was not limited to the pelvis. Reproductive or sexual symptoms were no more consistently associated with sexual assault history than GI pain, cardiopulmonary pain, or neurologic symptoms.

Similarly, in our study (Kendall-Tackett, Marshall, & Ness, 2003) of chronic pain in women from a primary-care practice, we compared women who had experienced child or domestic abuse with those who did not report such a history. The pain symptoms included on the review of systems were abdominal pain, pain or stiffness in joints or muscles, pain during urination, arthritis, back pain, and severe headaches. Women with an abuse history reported significantly more pain symptoms than women in the matched control group. But no one type of pain was particularly common. The results were the same for child abuse and domestic violence.

Pain Syndromes Have Commonalities

A broader view encourages us to consider what the various pain syndromes have in common. For example, people with fibromyalgia, irritable bowel syndrome, and

migraine headaches have lower pain thresholds and are more sensitive to pain and environmental stresses than their healthy counterparts (Hassinger, Semenchuk, & O'Brien, 1999; Silverman et al., 1997). IBS and fibromyalgia could be a result of a generalized disorder of smooth muscle. This type of disorder could account for the wide-range of pain symptoms including dysmenorrhea and migraine (Veale et al., 1991).

These commonalities also suggest some areas for intervention. For example, biofeedback and cognitive therapy can be helpful in breaking the pain-fear cycle that is common in abuse survivors with chronic pain. These techniques can help the body un-learn dysfunctional and hypervigilant responses to stress, which can dramatically increase pain. On the other hand, if these pain conditions are disorders of smooth muscle, then a medication that addresses the smooth muscles may ease symptoms. If pain is related to disordered sleep, improving sleep quality through medication and behavioral changes may lessen pain. At the very least, the commonalities between pain syndromes give us a good place to start.

Conclusions

Pain is common in abuse survivors. For many years, physicians wrote off these aches and pains as "neuroticism" or somatization. We know now that there is a physiologic basis for many of these symptoms including a lowered pain threshold and alterations in sleep architecture. What we know about the pathophysiology of abuse-related pain can also suggest treatments. Relaxation techniques can be useful, as can biofeedback. Both of these techniques teach patients to be more aware of their bodies, how they work, and what are some of the early warning signs of impending pain.

Patient education is another helpful approach. It involves educating patients about the source of their pain. This can be empowering and validating, letting patients know that their pain is not "all in their heads." Cognitive therapy can be helpful for abuse survivors in general because abuse often leaves its victims with an overwhelming sense of powerlessness. Patients may feel further victimized by their pain. Cognitive therapy can help them recognize these distortions, and take whatever steps they can to alleviate or minimize their symptoms. Learning the source of their chronic pain can slow the cycle of multiple doctors' appointments, surgeries and treatments.

In conclusion, a comprehensive approach to pain management will prove to be the most effective. Relaxation techniques, biofeedback, education, and cognitive therapy can be combined with medications, physical therapy, and lifestyle changes. This multi-faceted, mind-body approach can give adult survivors a sense of hope. It can also help them manage one of the most difficult symptoms of past abuse, and move toward healing their lives.

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Footnote

¹The authors included both contact and non-contact sexual abuse in their definition of sexual abuse.

Practical Tips for Collaborating With Physician Colleagues to Help Patient Heal Trauma Wounds

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In the past three articles for this column, we have seen examples of physicians and psychologists working together to address trauma within their communities (McCart & Melzer-Lange, 2007), healthcare clinics, generally (Fallot & Harris, 2007), and in primary care medical clinics (Ambuel & Hamberger, 2008). The issue of trauma is of significant concern to both psychologists and our medical colleagues, so it makes sense that the two disciplines are natural allies in the work of helping victims and survivors heal. Collaboration to achieve the latter goal is, however, not always an easy task, and consists of deliberate understanding of cross cultural differences between psychologists and physicians as well as execution of specific skills for communication and negotiation. In this article, I will describe some of these cultural issues and skills.

What is Collaborative Practice?

The essence of collaboration is the joint determination of goals, delineation of respective roles, including leadership when necessary, and establishment of communication patterns, including frequency and modality, between collaborating partners. This leads, theoretically, to a seamless and unified provision of care to assure the ultimate outcome of improvement in patient health and well-being (Holloway & David, 2005). Collaborative practice can take many forms along a continuum of involvement ranging from informal consultation to co-provision of care to co-therapy (Hepworth and Cushman, 2001). Informal consultation, sometimes known as a curbside consult, is usually quick, general and not documented, but attempts to answer a question related to a hypothetical or nonspecified patient's care, and quite often takes place in very informal settings such as the lunch line of the hospital cafeteria or, as the term implies, while in the parking lot. More intense levels of collaboration (e.g., formal consultation, co-management and co-therapy) typically comprise explicit specification of shared goals and respective responsibilities and roles, as well as increased communication. These more formal types of collaboration typically involve both partners sharing very specific patient information, patient informed consent to do so, and documentation of the collaborative process.

Why is Collaborative Practice a Good Thing?

There are several advantages to developing collaborative practice to help trauma victims and survivors. Patients benefit from the open communication between collaborative partners and the patient, reducing dysfunctional communication patterns, triangulation, and hidden agendas. Problems that arise can be addressed from diverse perspectives, increasing both opportunities and the number of available options. In addition, the open communication increases the educational components of medical and psychological therapies, as both disciplines can affirm, reinforce, and re-state in different terms consistent messages to

the patient. Finally, patients benefit from collaboration through reduction of isolation that comes from fractionation of care. In psychologist-physician collaboration, at least two healthcare providers are talking with one another and the patient about how to best help that patient albeit from two different perspectives.

Practitioners also benefit from collaboration. Information sharing increases efficiency and flexibility for addressing patient problems that might be missed practicing in isolation. Second, collaboration facilitates shared problem-solving for addressing highly complex issues that often present with trauma survivors. In addition, collaboration provides a forum for addressing and resolving potential conflicts, as well as developing consistent messages to deliver to the patient, thus reducing triangulation and splitting. Finally, collaboration helps both partners maintain focus on realistic treatment goals and maintain proper perspective in patient care.

Practical Tips—Getting Started

A basic understanding of the differences and similarities between the respective cultures of medicine and psychology is a good place to start with the collaborative process. Psychology and medicine share many values related to patient care. These include concern for patient welfare and wellbeing, as well as appreciation for the importance of the doctor-patient relationship as a tool for facilitating healing, recovery and care. Consistent with the values of psychologists, many medical specialties, such as oncology, primary care, women's health, pediatrics, trauma surgery, emergency medicine, are concerned about psychosocial issues that impact patient illness, health, recovery and prevention. Physicians, especially those in primary care, share psychology's value of helping patients change their behaviors to prevent disease or facilitate healing. Concepts such as motivational interviewing and stages of change are commonly discussed in primary care medical settings. Although there is much "art" to the practice of medicine and psychology, both disciplines value development of an empirical base for practice. Psychologists and physicians are concerned about credentials and scope of practice as indices of expertise and educational/professional attainment. Finally, both psychologists and physicians emphasize lifelong learning and continuing education.

The cultures of medicine and psychology also differ in important ways. For example, while psychologists are quite comfortable discussing and considering broad theoretical constructs as they may relate to patient care, physicians typically are interested in practical information that can be used immediately to help a patient, with theoretical considerations being of secondary importance. As such, they prefer consultation reports with behavior-specific recommendations rather than general recommendations such as "decrease depression," or "increase self esteem." Similarly, psychologists are typically quite contemplative when conceptualizing patient problems, using time as a tool to test and verify or disconfirm clinical hypotheses. Physicians, in contrast, tend to be more action oriented, and rely on protocols and



L. Kevin Hamberger, PhD

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Practical Tips for Collaborating...

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algorithms to guide interventions. In certain cases, physicians view time as an enemy wherein medical status can deteriorate rapidly, possibly resulting in death. Thus, in developing collaborative relationships with physicians, it will be important for psychologists to be cognizant of these potential cultural differences and take them into consideration when interacting with or providing a service for a medical colleague.

Practical Strategies for Developing Collaborative Relationships

Psychologist credentials can open the door to collaborative opportunities. It is important to seek a fit between one's credentials, skills, and clinical interests and the physician practice with which one is trying to connect. Thus, for example, highlighting a background in women's health issues would seem a good match with an obstetrics/gynecology practice or a family medicine practice, but less important to an orthopedic practice (unless the practice is tied to women's sports medicine). Credentials can be presented formally, as in sending out a card or brochure announcing the opening of a practice in certain areas of healthcare such as trauma. Informally, credentials can be communicated through networking and formally or informally discussing certain types of cases with physicians, demonstrating one's experience and knowledge of treating certain types of patient conditions.

Providing continuing education programs to physicians are formal ways to present credentials and demonstrate expertise. In health care settings, formal educational opportunities present themselves as hospital grand rounds and other sponsored continuing medical education programs. In general, educational programs should focus on the practical – things physicians can do to help their trauma patients, as well as specific ways psychologists can help them with their patients. Educational sessions should be interactive, and any handouts should emphasize practical things related to patient care.

Educational programs should also, as much as possible, emphasize evidence based practice, focusing on state of the science, while avoiding extensive discussion of esoteric experimental design issues that psychologists have been trained to appreciate and even enjoy. If the research presented is primarily from psychology, relate the key findings to medicine and clinical practice. Avoid highly abstract or politically-tinged theoretical discussion. This will not impress the audience nor result in increased referrals. Finally, during typical physician-oriented continuing education programs, it is not unusual for physicians to answer pages, leave the room, or appear to be focused on things other than the program. It is important not to take such behaviors personally. Rather, understand that physicians are very busy professionals who must frequently deal with difficult and pressing issues, sometimes at the expense of our lectures!

Another way to show physicians how we can help them and their patients occurs after we receive that first referral. Physicians frequently view referral to a mental health professional as tantamount to sending their patient into a black hole with no communication back on (a) whether their patient kept the referral appointment, and, if so, (b) how the psychologist is planning to help or (c) what recommendations for patient management the psychologist can provide to the physician. There are discrete steps we can take to both demonstrate our expertise and work

collaboratively with our physician colleagues. Step 1 is prompt, concise communication. Ideally, the first communication is to clarify the nature of the referral, for example assessment and recommendations for patient management or psychotherapy. Once clarified, discuss mutual expectations regarding frequency of communication. This will differ, depending on the nature of the referral. If it is for consultation and recommendations, communication will likely be in the form of a single report following assessment. If the patient is referred for therapy, communication might be more periodic, say at the beginning to detail the treatment plan, every few weeks to provide a progress report, and at the end to summarize treatment gains and follow-up plans. If co-management is the goal, communication will be more frequent, with both psychologist and physician initiating contact. In referrals that involve psychotherapy and co-management, the psychologist should also seek key information from the patient's medical record, including diagnoses, medications, potential complicating factors, etc. Another early task is to have the patient sign consent to share relevant information with the referring physician. Immediately following the first session, inform the physician through a memo that the patient was seen, and thank the physician for the referral. Step 2 is provision of practical, concise recommendations. Although discussion of intra-psychic dynamics and ego processes, self esteem, and family systems issues may be interesting to other psychologists, most physicians prefer concrete, concisely written, practical recommendations for things they can do to help their patients. Ongoing communication should include periodic written reports, but can also include occasional telephone contact and, if working with a secure internet network, e-mail messaging.

Collaborating with physician colleagues to help patients heal from trauma does not require the psychologist to work in the medical clinic. However, ongoing communication and contact with physicians and the medical system helps to (a) de-mystify the medical care process and increase appreciation of the healthcare culture and (b) facilitates physician appreciation of the unique contributions psychologists can make to the treatment of their patients. Collaboration can be a highly rewarding approach to the care of trauma patients and, as noted above, everybody, especially patients, benefit.

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Junior Colleague Mentorship Program

*Brian Hall
Kent State University
Student Affairs Mentorship Chair*

The Student Affairs Committee has been working to develop and implement a Junior Colleague Mentorship Program that will help bridge the gap between current professionals in the field with students and young professionals just beginning their careers working with trauma populations. The purpose of the program is to provide junior colleagues opportunities to reach out to mentors in the field of traumatic stress who are willing to share their expertise. We believe that this will foster better connectedness within our division and provide wonderful opportunities for our community to continue to grow and thrive. Currently, Division 56 is one of the fastest growing divisions in the APA, and student affiliates are active and flourishing, making up more than 25% of our membership. **Junior colleagues are eager to connect with current professionals and we hope this will serve as a bridge for stimulating and educational dialogue in our field.**

Benefits for Students/Junior Colleagues

Junior colleagues are encouraged to utilize their mentor relationship with a more seasoned trauma professional. We hope that a one-on-one relationship with a mentor will allow junior colleagues to solicit advice regarding training placements, get a “real life” perspective about trauma work, and provide guidance to junior colleagues who wish to gain more in-depth information regarding specific subsets of trauma work (e.g. trauma research, clinical work with particular populations). By working with a mentor who is not affiliated with a junior colleague’s school or training program, mentors are able to provide additional support and direction in an informal and non-evaluative format, so that junior colleagues can feel more comfortable asking questions and seeking feedback. This is not meant to work in replacement of supervision or educational instruction, but merely provide junior colleagues with an additional resource as they navigate through the stressful educational process.

Advantages of Mentorship—Mentor

The mentor may develop meaningful relationships with junior colleagues from a wide variety of training programs. Through the mentorship program, mentors may gain the opportunity to establish relationships with junior colleagues they may not have otherwise met. These kinds of contacts can lead to fruitful collaborations in research or clinical work either initially, or as the junior colleagues gain his or her own expertise. Mentors also have the advantage of giving back to the field by helping

junior colleagues through imparting wisdom and valuable information.

Application and Matching

Applications will be available on the Division 56 website or by contacting Brian Hall, Mentorship Chair of the Student Affairs Committee at bhall4@kent.edu. The application forms contain information regarding the research/clinical interests of the junior colleague and full division member, and what each would desire in a mentorship relationship (e.g., learn more about trauma research methods; share my expertise in working with childhood trauma). Each prospective mentor and junior colleague will rank order a list of four topics that are of particular interest to the junior colleague, and of particular expertise for the prospective mentor. We will then match the mentor and junior colleague based on this information.

Guidelines

The mentorship program is open to Division 56 student affiliates who are still training (graduate school or post-graduate training) and seasoned professionals in the field. The junior colleague and the mentor will determine the frequency and mode of contact they prefer. It is recommended that contact be made at least once a month. As a general guideline, the junior colleague and mentors will be matched for a period of six months, at which time the mentor and junior colleague can evaluate the relationship and decide to continue on, or request to be matched to another mentor/junior colleague. This process allows mentors to provide significant but time limited guidance while giving students the opportunity to be mentored by more than one professional in the field. As the six-month period comes to an end, a Division 56 student representative will contact the mentor and junior colleague to determine whether a new match needs to be made. Our expectation is that this negotiation will take place between the mentor and junior colleague.

We believe that professional development and growth is an important part of the field of psychology and hope that you will be interested in participating. For further questions, please contact Brian Hall, Mentorship Chair of the Student Affairs Committee, at bhall4@kent.edu.

Thank you for your interest in the Division 56 Junior Colleague Mentorship Program!



Brian Hall

Save the Date!

ISTSS 24th Annual Meeting
Chicago, IL
November 13–15, 2008

International Guidelines on Mental Health and Psychosocial Support in Emergency Settings Update

Elizabeth K. Carll, PhD, Chair
International Committee

The Interagency Standing Committee (IASC) **Guidelines on Mental Health and Psychosocial support in Emergency Settings**, which was launched at the United Nations in November 2007, has been increasingly recognized as an important interdisciplinary tool for action. As is the case for all guidelines, practical utilization is a gradual process.



Elizabeth Carll, PhD

A colleague, who is a psychologist in Australia, had asked my opinion of the guidelines as she became aware that I had participated in the consultation and review process of the proposed guidelines in 2005. She was particularly interested in what was unique about these guidelines compared to past publications by a variety of groups.

For those not familiar with the guidelines a brief background summary is included below.

Background

The IASC was established in 1992 by the U.N. to facilitate coordination of response to humanitarian emergencies. The basic focus of the IASC Guidelines is the need to strengthen coordination of necessary services in the wake of disaster, such as mental health and psychosocial services, as these overlapping services are often under separate auspices. The IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings is a collaborative effort of UN agencies and civil society and is co-led by the World Health Organization (WHO) and InterAction, a consortium of 160 U.S. based NGOs.

What Is Unique?

The recognition by all actors (civil society, private sector, and governments) involved in the extensive review process, that often there is weak coordination of services in the wake of disasters, leading to further problems down the road, was the impetus for the ambitious undertaking of developing a comprehensive agreed upon set of guidelines. As a result, the IASC Guidelines is perhaps the most reviewed document of its kind with hundreds of organizations representing civil society, the private sector, and governments providing input and recommendations.

The recognition of the importance of media outreach and public education by media outlets and key community resources was a unique aspect. Previous guidelines developed by various groups often made a cursory mention of the need for dissemination of critical information to the public via the media without any specific criteria and guidelines. As a result, the Dissemination of Information domain was critical to the success of the overall plan of action and the effective implementation of the guidelines.

Outline of the Key Actions for Dissemination of Information Following Crises

1. The formation of an information and communication team. The team may be drawn from local media organizations, community leaders, relief agencies, government, or other parties involved in the emergency response.

2. Regular assessment to identify key information gaps and necessary information for dissemination. This is a complex process and may include collecting daily information, as well as monitoring both harmful and good media practices. Good media practices may include providing specific advice through the media and inviting humanitarian workers to participate in the process. Harmful media practices may include the dissemination of hate messages, aggressive questioning of people about their emotional responses, failure to organize access to psychosocial support for survivors asked about their emotional experiences, and use of images, names and identifying information without permission or in ways which may endanger survivors, especially in times of war and conflict.

3. Development of a communication and campaign plan. The development of a system to disseminate useful information, educating local media organizations about potentially helpful and harmful practices, maximizing community participation, and respecting confidentiality and informed consent.

4. Creating channels to access and disseminate credible information. Generating a media and communications directory of local media contacts, a directory of personnel in the various humanitarian agencies involved in media, and identifying key members of the community who are influential in disseminating information.

5. Ensuring coordination of communication among personnel working in different agencies. Ensuring consistency and accuracy of information disseminated to affected communities. Also developing inter-agency platforms such as bulletin boards, where survivors can go to receive essential information including information on positive ways of coping with the disaster.

It should be kept in mind that the IASC Guidelines are not intended to be a cookbook approach, rather to be combined with conducting local situation analyses tailored to the most appropriate interventions for particular communities. The IASC publication can be obtained at <http://www.humanitarianinfo.org/iasc/content/products>.

Elizabeth Carll, PhD, is the chair of the International Committee of APA Division 56, a past president of the Media Psychology Division and editor of the two volume book set Trauma Psychology: Issues in Violence, Disaster, Health, and Illness, published by Praeger. She is a United Nations representative from the International Society for Traumatic Stress Studies and the chair of the Media/ICT Working Group of the UN NGO Committee on Mental Health. For further information, she can be contacted at ecarll@optonline.net

Nominations and Elections Committee

*Bob Geffner, Chair
Nominations and Elections Committee*



Robert Geffner, PhD, ABPP, ABPN

The Nominations and Elections Committee of Division 56 is soliciting nominations for the positions listed below. The election takes place in April 2009, and the elected people take office on January 1, 2010.

We encourage you to nominate a colleague or yourself. Please confirm with the candidate that she or he is willing to run for election before sending in her or his name.

The positions that are open this year are:

1. President-Elect
2. Member-at-Large
3. Secretary
4. Early Career Psychologist Representative
5. Student Representative

The positions are for three (3) years, except for the Student representative, which is for two (2) years. If you are interested in running for one of these five offices, please email me indicating your interest. Please do so by January 17, 2009. My email address is: bgeffner@pacbell.net.

Each candidate will have the opportunity to submit a statement of no more than 250 words that will be accessible to all voters.

Special Interest Groups

Desnee Hall, PhD

In only its second year, Division 56 has formed nine Special Interest Groups (SIGs) tailored to the interests of its members. These include groups focusing on Adult Survivors of Abuse; Child and Adolescent Trauma; Disaster Related Trauma and Response; Dissociation; Human Trafficking and Sexual Victimization; Medical Trauma, Illness, & Rehabilitation; Secondary and Vicarious Trauma; Trauma to Military and Emergency Personnel, and Trauma to Postcolonial Peoples.

Although still in its infancy, the Dissociation SIG, chaired by Harold Siegel, made its first presentation at APA's 2008 annual convention: "Dissociating Dissociation," a panel discussion framing the history of dissociation within the broader history of psychology. It is hoped that SIG presentations will become a regular part of the Division's contribution to APA.

These SIGs are actively recruiting members and forming committees. For further information, please contact Ricky Greenwald (rg@childtrauma.org) for the Child and Adolescent

Trauma SIG, Harold Siegel (linkmets@aol.com) for the Dissociation SIG, Sara Maltzman (smaltzman@cox.net) for the Secondary and Vicarious Trauma SIG, and Pilar Hernandez-Wolfe (pilarhw@jhu.edu) for the Trauma to Postcolonial Peoples SIG. All other questions may be addressed to Special Interest Group Coordinator Desnee Hall (DesneeHallPhD@aol.com).



Desnee Hall, PhD

Additional SIGs will be formed if there is sufficient member interest. Those currently under consideration are: Complex Trauma; Health Effects of Trauma; Intergenerational Transmission of Trauma; Intimate Partner Violence (contact Dawn Griffin at drdgriffin@sbcglobal.net); Neuroscience of Trauma; Refugee Issues and Torture; Trauma from Discrimination, Marginalization, and Oppression, and Trauma in the Middle East (contact Ilene Serlin at iserlin@ileneserlin.com). Contact Desnee Hall with all other questions.

Additional Special Interest Groups may be proposed by submitting a 100–150-word description to the SIG Coordinator. These SIGs will be approved by the Executive Committee as soon as 10 members of the Division indicate interest in active participation in the SIG.

Division 56 (Trauma Psychology) Mission Statement

The APA Division of Trauma Psychology provides a forum for scientific research, professional and public education, practitioner information, and the exchange of collegial support for professional activities related to traumatic stress. By doing so, we facilitate a state-of-the-art response by psychologists and other mental health practitioners, that include improving culturally sensitive service delivery, so that our understanding of trauma psychology continues to progress and we can make important strides in reducing trauma.

Please give all 10 votes to Division 56, or at least some of the votes since we missed a second Council Representative by only 50 votes last year!! VOTE DIVISION 56!!

Child and Adolescent SIG

Athena A. Drewes, Secretary

The Child and Adolescent SIG is alive and activated! We are happy to report that efforts are under way for collaboration with Tony Mannarino and Division 37, Society for Child and Family Policy and Practice, on a joint three-hour symposium for the 2009 APA convention. The symposium will focus on different types of empirically supported treatments for traumatized children. It will also highlight the common elements across the treatments. Additionally, there will also be a skill-based section on play-based interventions that can be incorporated with CBT when working with young children. This symposium will be a good opportunity for supporters

of CBT and EMDR to have a balanced discussion. Additional collaborative efforts are also being pursued.

There are future plans for our SIG to have a meeting and presentation in the hospitality suite, child and adolescent articles in future Division 56 newsletters, and SIG listserv discussions. We welcome your input and ideas to help shape our future! Individuals working with or interested in children and adolescents experiencing trauma are welcome to join the SIG.

Chair, Ricky Greenwald, rg@childtrauma.com; Secretary, Athena A. Drewes, adrewes@astorservices.org; Treasurer, Elke Rechberger, differentsolutions@gmail.com; and Membership, Cindy Weisbart, cweisbar@Peds.umaryland.edu. We look forward to hearing from you!

SIG 18: Secondary and Vicarious Trauma

Sara Maltzman, PhD



Sara Maltzman, PhD

Our SIG had its first annual meeting during the APA convention in our Divisional Hospitality Suite. We agreed to develop a proposal for the 2009 APA convention on the topic of self-care for practitioners. We are in the process of contacting and confirming the two primary speakers. We also have the potential opportunity to collaborate with Division 17: Society of Counseling Psychology (SCP) on the symposium.

SCP has been very involved in trauma work with rape survivors. Additionally, it has an active Health Psychology

Section for whom the symposium would be relevant (for example, some members work with hospitalized cancer patients).

We also would like to be a resource regarding self-care for Division 56. SIG members were interested in developing regional support groups. Our first step is determining the interest among SIG and Divisional members. If you would like to participate in a support group, please let me know. The logistics might be difficult, but not insurmountable. If face-to-face meetings are not practical, scheduled conference calls could be considered.

If you are a Division 56 member or affiliate who is interested in joining the SIG and possibly participating in the symposium as a discussant, or participating in a regional support group, please contact me: smaltzman@cox.net.

Trauma Symposium Available Online

Unable to attend the convention in Boston? Or confronted with too many wonderful choices? Listen to our featured program and download slideshows from the presenters at: www.apatraumadivision.org/program.php

These downloads are a great way for people unable to attend the convention, or too busy to make it to a program, to sample some of the riches of the Div. 56 convention program.

A reminder that the Call for Proposals is now up on APA's website. A link to that call can also be found at the URL above.

Laura Brown, Div. 56 web editor

We're interested in our Members...



Kathy Kendall-Tackett

The *Trauma Psychology Newsletter* is interested in getting to know you and what you're doing. Have you been promoted or just had a new book or paper published? Are you speaking at a conference or being recognized for your work? Please let us know so we can share the news with your colleagues in a column devoted to our members' accomplishments. Please send information and details, including any relevant photos, to Kathy Kendall-Tackett (KKendallT@aol.com).

Division 56 (Trauma Psychology) Mid-Winter Meeting, Morning Session

March 1, 2008
Baltimore, Maryland
10:00 a.m. to 12:00 p.m.

Attendees: Bob Geffner, Judie Alpert, Chris Courtois, Priscilla Dass-Brailsford, Nnamdi Pole, Sylvia Marotta

By Telephone: Elizabeth Carll, Harriette Kaley, Toby Kleinman, Beth Rom-Rymer, Desnee Hall, Lisa Butler, Gil Reyes, Richard Thompson, Joan Cook, Patrick Meade

Guests: Carole Warshaw, APA President-Elect James Bray

Bob welcomed the group to the meeting and the conference call, and reviewed rules for participating in the meeting. Due to the high number of topics that needed to be covered in a limited amount of time, Bob requested that reports and discussion be concise.

Highlights from the Summit on Interpersonal Violence

Bob summarized highlights from the Summit on Interpersonal Violence that took place in conjunction with the Mid-Winter meetings. There were 450 registered for the Summit, which was well over the 300 participants that we projected. Division 56 was prominent as a co-sponsor of this highly successful event. Several members of the APA Board of Directors were there, in addition to a number of APA staff members. Nineteen divisions collaborated on the Summit, and Divisions 56 and 35 were the lead divisions. In addition to the 19 divisions and numerous other organizations that participated, several others expressed interest in participating in future meetings, including Division 55.

Sylvia was introduced as the official Div 56 representative to the Summit. She summarized the meetings for the group. She noted that the arrangement of sessions provided a nice balance between plenary and break-out sessions. Many interesting ideas emerged from the break-out sessions, including a proposed think tank on directions for the field. One deficit identified was the need for trauma training in graduate programs. Another issue that was discussed was the need for multi-disciplinary advocacy on Capitol Hill. Prevention of violence was also discussed in that it's better to teach about healthy relationships rather than just focus on violence. The developmental perspective presented in sessions was also useful. Sylvia will be writing up a summary of the Summit for the newsletter, the *Monitor* and possibly other APA publications.

Judie added that there were many students at the meeting, which she thought was encouraging for our field. Students expressed a need for mentors in the trauma field, noting that they often did not have mentors at their

universities who were knowledgeable about trauma and disaster.

Bob indicated that half of the attendees were academics or researchers, 30% were practitioners, and 20% were students. The poster sessions included 82 posters and featured many internationally recognized researchers in the field. The posters and all the PowerPoint slides will be available on the Summit Web site. Bob emphasized again that this was a very high profile event and that it brought a lot of attention to the Division. Many attendees expressed amazement that we've only just become a Division (official at the February 2008 Council meeting). We are now on par with some of the larger, more established Divisions that have more people and resources at their disposal.

Both Nnamdi and Chris indicated that this meeting could indicate the start of a movement within psychology and was not simply a one-time event.

Chris announced that Bob and Jackie White got APA Presidential Citation Awards from Alan Kazdin for all the work they did on behalf of the Summit as well as throughout their careers.

Committee Reports

Carole Warshaw joined the meeting at this point. Carole is a psychiatrist and will work with us as a liaison to other organizations in trauma and psychiatry.

Harriette reported as the Representative to the Divisions for Social Justice. At the recent Council meeting, the Council unanimously passed the revised Council Resolution on Torture unanimously. Beth summarized what occurred at the meeting and how they gained the unanimity. Both Beth and Harriette reported that this new resolution has calmed the debate on this issue within the organization and provided unity.

APA President-Elect James Bray joined the meeting at this point. Bob asked him if people who resigned from APA in protest might rejoin based on the recent Council Resolution on Torture. Beth shared her impressions on whether it might have an impact. She felt that it might bring people back to APA, but that it would be a gradual process. Harriette was concerned that the Resolution might not be worded strongly enough to bring the people who resigned back.

President-Elect Initiatives

James Bray will take office in 2009 and is planning the initiatives that he will address during his presidency. James complimented the group on an excellent Summit. He proposed that we collaborate on two issues that he wants to address during his presidency. The first is that he will convene a task force on the future of psychological practice



Kathleen Kendall-Tackett, PhD

Div. 56 Midwinter Meeting Minutes

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in spring 2009. He wanted to respond to concerns that APA is not doing enough to support practitioners. This task force will be developing policies for APA. He encouraged the Division to nominate task force members within the next couple of weeks. The second issue has to do with the way the Convention is organized. Both scientists and practitioners have indicated that it really doesn't meet their needs in its current format. He proposes an experimental approach; to have a convention within a convention, providing sessions around specific topics, with 2-3 hour skill-based programs. Divisions will need to donate program hours in order for this to happen. For example, a topic could be violence and trauma with clinical interventions. This program would be embedded in the convention program to address some of the concerns. Bob indicated that we are actually doing that this year as an outgrowth of the Summit. James agreed that we were indeed at the forefront in terms of an integrated, cross-cutting program for the convention.

Elizabeth complimented James on the two initiatives, indicated that these will address many of the concerns that practitioners have, and feels that this focus can increase membership. Judie expressed her interest in helping him during his presidency. But also asked how APA can help us. For example, how can we get more visibility within APA? How can we get trauma issues more integrated into both clinical and research training? Bob also raised the issue of DSM-V and the possible changing of trauma diagnoses. Chris indicated that we will need the full force of APA behind our Committee on that issue. Bob reiterated that the Division would like to work with APA on these initiatives. James responded that if we want to influence curricula, we need to work with Educational Directorate. He suggested that we might develop a model curriculum that could be vetted through APA. James also said that APA is in the middle of a \$7,000,000 update of their Web site. The new Web site is one potential place to make our materials on trauma available for people to download. The Web page will go live in 2009, and parts of it are being re-designed now. This new site will also give Divisions space, with all the pages having a similar look. James then left the meeting.

Discussion continued concerning DSJ report and issues. Both Judie and Chris complimented Harriette on her report. Nnamdi also raised the issue of members rejoining APA and felt that this issue is broader than just the ban on torture. Are psychologists part of organizations that deny people their basic rights? And is that unethical? We might find that this fits into a broader number of issues as well, such as psychologists who work in prisons and other similar settings.

Bob indicated that we will continue this discussion at APA and that Nnamdi will be presenting a panel discussion on this. We will continue to work with other divisions and with Divisions for Social Justice. Harriette left the call at this point.

Task Force on Psychologists Role in Interrogations

Nnamdi reported on the work of his Task Force to date. He has finalized the task force and members of the group. The group had a phone conference and discussed the expertise of each group member and what they will work on. The following wording regarding their mission was agreed upon:

To prepare a report to the EC of Division 56 in which there is consideration of the role of psychologists in national security interrogations from the perspective of trauma-oriented psychologists. This report should include a review of current empirical and clinical knowledge on the possible and probable short-term and long-term psychological consequences of known (or suspected) coercive interrogation techniques. It should clarify which aspects of the interrogation process are potentially traumatic for both the interrogated and the interrogator. The task force will not conduct investigations into allegations of wrongdoing by psychologists or others nor should it seek to make recommendations beyond the expertise of its members.

The Task Force focused on refining the outline for their final report. They currently envision a report composed of the following sections: (1) Overview of Report, (2) Introduction of Report (including a review of the relevant APA policies and a timeline of key events influencing the interrogation story), (3) What are Possible and Probable Consequences of Known and Alleged Interrogation Techniques to Both the Interrogated and the Interrogator?, (4) What Kinds of Interrogation Practices are Likely to Be Traumatic? (5) What Kinds of Interrogation Practices Would Reduce Risk for Trauma? (6) Conclusions, (7) Recommendations, and (8) Bibliography. Nnamdi indicated that one difficulty of his task is "charge slippage," trying to cover too many topics and related issues. So the touchstone issue that they use is "how does this relate to trauma"? A related issue is when psychologists haven't done anything, but find out that they are part of a larger organization that is doing unethical things, realizing that they are part of the organization. Nnamdi indicated that he wants to present their findings at the summer Convention and to get feedback at that time.

Carole asked if the Task Force has a member who is experienced with people who have been tortured. Nnamdi indicated that a Task Force member was an expert on that topic. Judie recommended that we make the report available to people who are interested in this issue. The group complimented Nnamdi and the Task Force on the excellent work they have done so far.

DSM-V Task Force

Bob announced that Terry Keane is the new chair of the DSM-V Task Force. Chris reported for the Task Force as Terry was not able to attend the meeting. She indicated that the group needs to get going and is looking forward to working with Terry. Bob indicated that this will be a long-term task force, and one reason that Bob invited Carole is because she is from the American Psychiatric Association and has an interest in trauma. Carole reported that some committees within the American Psychiatric Association

have also tried to address the issue of trauma-related diagnoses in the DSM. Bob asked for suggestions for other Task Force members.

Bob has not yet heard from Jaine regarding the action of her Task Force on Trauma in the Military and Their Families. Judie will follow-up with her.

Program Committee

Joan reported that we were allocated 14 convention hours (but received 4 additional hours). There were 26 submissions for papers; we accepted 9 and 10 became posters. We have 2 poster sessions, 10 symposia, 2 workshops, 1 town hall, 1 presidential address, and 1 social hour. We also received 3 donated hours from other divisions. We had 34 reviewers from across the country. Joan and Richard are taking the lead on planning programming for the Hospitality Suite. Joan is finalizing the convention program schedule and Richard is finalizing the program for the suite and will send it out to the listserv when it is finished.

The Executive Council meeting is Thursday 5–10 p.m. in Boston, and we will bring in dinner. We are having our reception Friday night and Taylor and Francis is co-sponsoring the event for – Bob is hoping to obtain \$3,000 from them and also funds from PI again. This reception is a joint venture among Div 56, PI, and DSJ.

For the 2009 program, we need to be thinking about providing continuing education workshops as these will provide revenue. Joan indicated that many sessions that we offer in the 2008 program will have continuing education credits, which will bring in attendees. Richard Thompson is the 2009 program chair, with Dawn Hughes as co-chair (appointed by Steve).

We recently learned that APA will waive registration fees for two non-APA members and two members whom we invite to participate. Judy Cohen is interested in attending. So Bob will let her know that we will waive her fee. Joan will follow up with another person.

Bob suggested that we offer time in the hospitality suite for the Special Interest Groups. We might also offer some time for the papers we turned down. It was agreed to authorize payment to APA for \$300 to advertise our hospitality program in the convention program, and this will increase our visibility. If there is extra time, we should have people available to have some conversations with people on trauma-related topics. One idea is a student conversation hour. Patrick will forward some topics that would be helpful for students and tie it in with their mentoring program. Another discussion topic for the suite could be for those who teach trauma to discuss programs and syllabi for courses. There's a real need for this. If we are telling people that they need to include trauma in their curricula, we need to show them some model curricula. Bob will ask Anne dePrince to organize a program for the suite on teaching of trauma. Carole suggested that if APA advertises that we let local groups around Boston know about the reception and hospitality program. Joan pointed out that we do not have unlimited hours in the suite since we share it with another division. However, these ideas could fit within our blocks of time.

Judie raised the possibility of inviting Judith Herman

to present at the convention since she lives in the Boston-area. The program is full though. Bob may be able to share his hour with her if she is available. Judie suggested a trauma pioneer award to be given at the convention, and the possibility of Judith Herman for the first one. Discussion occurred. It was approved to provide extra funding for such an additional award, and to have the Awards committee add this to their deliberations. The consensus of the meeting was to give such an award this first year in Boston to Judith Herman.

Priscilla has been working with Division 17 in the Boston area. She will let them know about the trauma program. Joan will send brochures for her to share.

Bob suggested that we liaise with other divisions for sharing a suite for future meetings, and feels that more divisions will be willing after the Summit. Division 37 is one possible group we can ask.

Council Vote to Approve our Division

Beth reported on the vote by the Council of Representatives to approve our Division. At the Council meeting 20 people were present who are Division members. The vote in Council to approve our Division was unanimous. Another division the previous day was voted down. Our approval was a strong vote of confidence and indicates that we are doing quite well.

Bob asked for someone to take the lead in memorializing the history of Division 56. We might also present an award to Judith Herman (see above) at the reception that celebrates our becoming an official Division. Beth is willing to chair the event. She will work with Lisa and the Awards Committee. Judie asked Lisa and Beth to talk with Laura, Bob, Terry and others involved in the founding of the Division for background information. Chris also agreed that we have a pioneer/mentor award.

In concluding the morning meeting, Bob indicated that the group would review the budget, discuss the journal, and hear other committee reports after lunch.

Bob indicated that he had concerns about the contract for the journal that he wanted to review with the group before Gary VandenBos arrived for the afternoon meeting. He was especially concerned about some of the vague language regarding overhead and right of first refusal.

The meeting was adjourned at 12:00 and resumed at 1:30 p.m.

Respectfully submitted,

Kathleen Kendall-Tackett
Secretary, Division 56

[The meeting was recorded and minutes were taken from the recording. Notes were taken at the meeting by Elizabeth Carll.]

Division 56 (Trauma Psychology) Mid-Winter Meeting, Afternoon Session

March 1, 2008
Baltimore, Maryland
1:30 p.m. to 5:00 p.m.

Attendees: Bob Geffner, Chris Courtois, Nmandi Pole, Priscilla Dass-Brailsford, Laura Brown, Sylvia Marotta, Judie Alpert,

By Telephone: Elizabeth Carll, Beth Rom-Rymer, Lisa Butler, Patrick Meade, Desnee Hall, Gil Reyes, Richard Thompson, Toby Kleinman, Jennifer Freyd, Sandra Mattar

Guests: Gary VandenBos, chair of APA Publications

Division Journal

Bob opened the discussion of the Division journal by indicating that this is one of the most important decisions we will make. It will impact the quality of the journal, our prestige and our income. The contract that we sign will lock us into a 5-to-10-year deal. Given that, Bob expressed concern about the current wording of the contract. He was especially concerned about terms, such as "overhead," which were not defined. This vague wording could mean that we would never see income depending on how APA chose to define the term. Another concern was the right of first refusal. If vaguely worded, this part of the contract could potentially mean that we can never go to another publisher once our contract term has ended.

Bob indicated that he has spoken with Division 37, who publishes their journal with APA, and that they are unhappy. They are currently negotiating with Blackwell. Laura indicated that Blackwell was not interested in publishing our journal because we are starting a journal from scratch. She has spoken with several other divisions who are quite happy with APA, including Division 45. Gary is really interested in publishing our journal and is more than willing to work with us. Bob said that we have decided to go with APA as our publisher, but that we need to safeguard the interests of the Division.

One way to deal with the expense of the journal is to charge our members more for it. If we want to go that way, Laura indicated that we should vote on it as a group. The group decided to keep the price low for now and to use the journal as a recruitment tool for membership. As agreed upon, a subscription fee of \$20 will be added to current dues starting in 2009, which is a very reasonable price for a journal.

Another issue the group raised is whether an electronic version of the journal would be available. APA cannot provide journals in this format yet, but they are headed in that direction so it will be available in the next couple of years.

At this point, Gary VandenBos, Chair of APA Publications, joined the meeting. Bob indicated that we wanted to come to a decision soon and have the first issue

of the journal available by March, 2009. We also want to keep the \$20 fee for members to receive the journal. Bob expressed his concerns about the current contract that he wanted to resolve.

The issues are as follows:

- **10-year renewal clause.** The group wanted a five-year renewal option.

- **Marketing.** There is not enough information about how APA would market the journal to people outside the Division. We would like an aggressive marketing plan.

- **Statements of expenses.** These are not delineated in the contract (e.g., expenses, customer service). Bob expressed concern about how high those can get, and the amount of carryover. He requested clarification specifying expense calculations in the contract. The amount of money that we would be taking in initially was much lower than we originally anticipated and would need more money from the journal to be in line with what other journals are offering.

- **Right of first refusal.** Bob was also concerned about first right of refusal if we are unhappy. The way the contract is currently worded, we have no way out if we are unhappy at the end of the contractual period. We need to modify the contract language on this point as well.

Gary responded that he wanted to work with the Division and forge a relationship that benefits both. He also wants to protect the interests of both the Division and APA.

Toby Kleinman entered the discussion at this point.

Gary indicated that all financial parameters in publishing interact with each other: honoraria, number of pages, royalties. If we want more revenue, we need to raise the price. But if we work with APA, a minimum income is guaranteed.

All expense systems within APA are formula driven, so expenses can be accurately estimated. We also have the right to look at the APA books to see how money is spent down to the penny. Our expenses include a manuscript coordinator (fixed fee, \$5,000) and the JBO tracking system to track manuscripts, also a fixed fee. The service center assessment is based on the number of pieces moved and is based on postage rates. Marketing expenses are also based on number of pieces moved. The first year, there would be more marketing expense to get the journal launched.

Gary informed the group that our journal, as an APA journal, would have 3,500 institutional subscribers from day one. That means people are using our materials, which is how we will generate income. In the first year, we will not receive much revenue based on electronic sales. Gary expects the journal to be operating in the black by the third year. Revenue will continue to grow every year after that.

Bob requested that Gary provide details about the expenses he expects to incur. He also requested that we have the option of refusal if there is an issue that was not financial



Kathleen Kendall-Tackett, PhD

and that cannot be resolved (e.g., lack of satisfaction with marketing). Finally, he requested a change in the initial term (e.g., 7 years).

Bob suggested that Toby, Gary, Laura and Bob discuss the specific contract language to meet these requirements. Laura suggested that she bow out of the negotiations, and that we have a deadline for finalizing the contract (perhaps within 2 weeks). Gary made arrangements for follow-up on the contract and left the meeting. Toby will communicate directly with Gary on language on right of first refusal.

Editor/Co-Editor Selection Committee

Bob indicated that we already have a Publications Committee and that Topher is the chair. We haven't yet activated that committee, but when we do the new editor will be a member of it. Once the committee is established, this committee will set up the process of selecting the next editor. Bob indicated that Steve expressed interest in being Editor for the first term. Kathy Kendall-Tackett and Chris Courtois expressed interest in being Co-Editors. Laura indicated that she has asked for letters of intent from Steve, Chris and Kathy. The group discussed the distinctions between Editor, co-Editor, and Associate Editor. Once we obtain these letters, Laura and her committee will make a recommendation to the Council for a vote. The Publication Committee will work on establishing procedures next year for selection of an editor, and forward its final recommendations for Editor/Co-Editor selection procedures to the Executive Council for approval.

Budget

Outgoing treasurer Melba Vasquez filed the budget report that was in the agenda packet. Beth's 2008 budget was sent separately. We budgeted \$6,000 for the meeting, but the expenses of many attendees were covered by other divisions and/or the Summit. So we spent less than we budgeted for the Mid-Winter meeting.

We had \$27,468 in the bank as of 12/31/07. We will need to build a budget to cover future Mid-Winter meetings. Projected \$36,774 income for 2008, with projected expenses being \$31,950. Net income: \$4,824. Beth will send a final budget based on motions voted on in the meeting. Our account is in a money market that is drawing interest.

Beth reviewed the 2008 budget and items that have changed between the 2007 and 2008 budgets. The group voted on a number of specific budget requests.

Requests for Funds for Committees and Task Forces

- Approved covering convention registration fees for the Student Award winner.
- Approved increased Secretary budget to \$500 to cover conference call expenses.
- Approved an increase of \$1,000 for Web site maintenance.
- Approved \$12,000 for newsletter.
- Approved \$3,000 and \$500 for presidential suite and refreshments in the room during the convention, respectively.
- Approved an increase of \$200 to the Awards Committee to cover the additional award.
- Approved an increase of \$500 to the Membership

Committee to promote membership.

- Approved \$200 for each of five Task Forces (total \$1,000).
- Approved the Science Committee request for \$1,000 for development of the Wikipedia project.
- Approved \$1,500 for presidential travel (three trips per year) as a general budget item.
- Approved a request from the International Committee for \$100 to cover conference calls and other materials.
- Approved \$100 for conference calls for the Disaster Relief Network. (Gil can request more if needed.)
- Beth will add these items to the final budget and send it to the Executive Council.

Motion: Motion to approve the budget as now amended. Chris motioned. Judie and Priscilla seconded. Motion carried unanimously.

Membership

Bob reported that our membership numbers have dropped by 150 members. A drop in membership the first year is customary for all new divisions, but our membership numbers have dropped less than other divisions. We need to continue recruiting colleagues for the Division. We also need to increase our efforts to recruit students, early career psychologists, psychologists from diverse backgrounds, and members of other organizations with an interest in trauma.

Bob indicated that Steve Gold, who was not able to attend the meeting, wanted to create an Executive Council position on early career psychologists. Bob said that there are two ways we could go about that. First, this person could be a Committee Chair, which does not require a bylaw change. Second, we could create an actual board position. That option does require a bylaw change. The group discussed options. Laura recommended this be an elected position, which involves a bylaw change. She also suggested that Bob could appoint someone now as the representative to the Board, and Committee chair. The Representative/Chair would be on the Executive Council.

Motion: A motion was made to approve a representative for early career psychologists (ECP) who would then chair an ECP committee on the Executive Council. Beth seconded. Motion carried unanimously. Bob will appoint an early career psychologist and solicited nominations. An early career psychologist must be less than seven years post-doctorate. A motion will then have to be approved at the general business meeting at APA to amend the bylaws.

Desnee reported on the activities of the Special Interest Groups, and indicated that we have three new SIGs up for approval.

- Adult survivors of abuse
- Disaster-related trauma and response
- Medical trauma: Illness and rehabilitation

Motion: Motion to approve the three new SIGs above: All were approved. Chairs will be appointed soon.

Motion: Motion to approve new SIG on secondary and vicarious trauma. Approved.

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Div. 56 Midwinter Meeting Minutes

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Business Items

Priscilla suggested that we change the name of the Diversity and Multicultural Concerns Committee, dropping “concerns” from the title. The new proposed title of this committee would be the Diversity and Multicultural Committee.

Motion: Motion to approve renaming the Diversity and Multicultural Concerns Committee to the Diversity and Multicultural Committee. Judie seconded. Approved unanimously.

Priscilla proposed that we have a training session for Executive Council around diversity issues. Our next Mid-Winter meeting coincides with the Multicultural Summit and this might provide an excellent opportunity to incorporate diversity issues more fully into the Division. Bob suggested that we start brainstorming at APA about how we can do this. One possible suggestion was allocating time in the convention hospitality suite so we can discuss this in more detail.

Motion: Motion to allocate time in hospitality suite for the Diversity and Multicultural Committee to plan an event for the board on multicultural issues to be presented at the Mid-Winter meeting. Unanimously approved.

Motion: Motion to increase the budget for the Diversity and Multicultural Committee by \$100 for conference calls. Laura seconded. Unanimously approved.

Action Items

Our next Interpersonal Violence Summit will be in 2010. Divisions 35 and 56 will be the two lead divisions. After that, the Summit will become an ongoing event. We need to reaffirm that we want to continue to be a lead division. There is no financial commitment that we need to make at this point. We will likely need to rent a room and pay for a telephone for call in.

Priscilla wanted to know how we could increase the number of divisions who are involved with the Summit. Bob suggested we continue dialoging with APA presidents and presidents-elect.

Motion: Motion to approve our involvement as a lead division for two more events (2010 and 2012) as biannual interdivisional Mid-Winter Conferences, and to hold our Mid-Winter meetings in conjunction with these. Judie and Chris seconded. Approved unanimously.

Bob agreed to continue to take the lead on this to get it organized. Jackie White (current president of Div 35) has committed to continue to work on this event as well. The President-Elect (Steve) would also be involved (he was involved this year too as part of the planning committee, but was not able to attend the Summit).

Task Force on Violence and Abuse

Bob also raised the issue of whether Division 56 should try to institutionalize issues of violence and abuse within APA. He suggested appointing a task force that would

address violence and abuse in relationships that will deal with policy issues within APA. The ultimate goal would be to have APA form a permanent standing committee on abuse and violence. This was approved.

Task Force on Ethics in Forensic Issues Involving Trauma

Bob will appoint a second task force on ethics concerning forensic issues in trauma and abuse cases. The focus will be on psychologists who testify in cases who are not necessarily qualified to testify on abuse and trauma. This was approved.

Laura requested that Bob forward information on these task forces to her so she can add them to the Web site. A request for nominations for Chair was made; these should be sent to Bob.

Ethnic Minority Representatives to the Council of Representatives

Laura reported on the proposed bylaw change for APA that would create positions for four new Council Representatives who would represent the four ethnic minority psychological associations. The Council had approved this unanimously, but when it was sent to the membership for a vote, the bylaw change did not pass by 117 votes. Laura described the issue and emphasized its importance. The Executive Council voted to approve this APA bylaw change. Laura will draft text for the Web site declaring that Div 56 supports this bylaw change.

Use of Division Listservs by APA Presidential Candidates

The next issue discussed was on developing a policy regarding use of Division listservs by candidates running for APA president. Some divisions prohibit this. Others allow it with some parameters on what candidates are allowed to do. Some let everyone advertise. Others let no one do it. Others will tell members if a member of their division is running for president, but will not let them directly campaign.

Based on the ensuing discussion, the group decided that there would be no campaigning whatsoever on the listservs. Once a nomination is set, any person can approach the Executive Council for an endorsement. If the Executive Council decides to endorse someone for president, we will let the listserv know. We can announce which Division members are running for office on the listserv, but they need to let the president or secretary to know first. We will also allow candidates to make a one-time announcement or statement of interest.

Judie suggested that we invite all candidates running for president to come to our meeting at the convention. We can also have candidates write up something for the newsletter on how they would handle issues related to trauma psychology.

Special Issue of Division 29 Journal on Trauma

Steve requested that the Executive Council discuss the possibility of approaching Division 29 to see about reprinting the special issue of their journal that focused on trauma. The group approved for him to do this.

Increasing Revenue

Regarding increasing revenue, Elizabeth proposed that we appoint another member for the finance committee. Some ideas for generating revenue include approaching other publishers to advertise in the newsletter, increasing the number of items available for sale at the silent auction, and increasing other sources of advertising revenue. Bob is soliciting nominations for the Finance Committee. Beth, Judie and Terry are the current members. Patrick indicated that the Student Committee is targeting more than 300 graduate programs in psychology in an attempt to increase student membership numbers. Currently, one third of APA members are students. Elizabeth reported that we have raised \$4,950 so far in advertising revenue in the newsletter.

The group then discussed another possible source of revenue: allowing individuals and/or groups to place business card advertisements in newsletter, possibly on a Members' Practices page. This would mean adding pages to the newsletter. Each additional page costs \$90, but could generate \$700 in revenue. However, there was some concern expressed about having these types of ads. Regarding the Web site, Laura raised a couple of issues. First, since the newsletter is also published on the Web, it would mean that the advertisements were published in hard copy and online. Since this means adding pages of the newsletter, there would be increased costs for setting up the online version of the newsletter. And we would need to decide which Web page the advertisements would be placed on as this should be reflected in the cost of the ad. Right now, we don't know which pages on the Web site have more traffic, and where the ads would be placed. We would need to find that out before setting prices (i.e., high-traffic pages should cost more than low-traffic ones). We also want to be careful that we do not add any costs to the Division. Bob suggested that we find out from our Web developer what it would cost to have an ad page. We also need to consider whether other divisions are doing this. Elizabeth reported that most she has been in contact with do not—but they are interested in possibly doing it.

Bob suggested that we try including business card advertisements for next issue of the newsletter, with a disclaimer statement that advertisements do not constitute endorsement. Bob will work with Topher to set up procedures for handling these ads and will see what the response is. We will visit this issue again at the August meeting.

Membership

Sandra Mattar joined the call at this point. She reported that APA has forwarded more than 700 names over the past three months of people who have expressed interest in membership on their dues statements. Sandra is sending out hard-copy letters and membership brochures. Bob suggested that she might want to send a sample newsletter to prospective members as well as this is a great recruitment tool. He asked Sandra to contact Topher about the cost of doing this.

Sandra reported that we currently have 950 members. Last year at this time we had 500-600 members. The

membership categories are as follows: 644 full members, 14 associate members, 156 student members, 102 fellows and 34 affiliates.

Sandra will send a list of prospective members to the Executive Council list to see if there are people on that list that we know and can call to see if they would like to join. This list will not be shared with the general membership. Sandra also suggested that we send a letter to all APAGS members to join the Trauma Division. Sandra motioned that we offer APAGS members a one-year membership for free.

Motion: Motion to offer APAGS members a one-year free membership. Patrick seconded. The Motion was approved.

Sandra suggested that Bob draft a recruitment letter to say that we are now a Division as part of a membership marketing campaign. Sandra will draft it for Bob to edit and send out. She also suggested that Bob send a video clip announcing that we are now a Division to send to APAGS.

Final Issues

The group discussed the need for broadening our group of workers to involve people other than the current Executive Council. Bob suggested that each Executive Council member come up with two names of colleagues who might like to get involved in the Division.

Chris announced that the *Encyclopedia of Psychological Trauma* is nearly completed and going to press.

The meeting adjourned at 5:20 p.m.

Respectfully submitted,

Kathleen Kendall-Tackett
Secretary, Division 56

[The meeting was recorded and minutes were taken from the recording. Notes were taken at the meeting by Elizabeth Carll.]

Are you a book author who receives royalties from your work on trauma? Consider donating some portion of your royalties to Division 56; it's an easy way to support the work of the organization and give back to the field of trauma psychology.

Are you looking for a good end-of-year tax deduction? Write a check to Division 56, which is a not-for-profit organization. Have ideas about how to raise money for the Division? Get in touch with any of our elected officers to share your ideas.

Presidential Voice: State of the Division

continued from p. 1

Division 56 members \$20 per year. To think this is happening in just our second full year!! This journal will complement our outstanding newsletter that is published three times per year under the guidance of Topher Collier and his team. Our newsletter is quite an accomplishment for such a new division!!

We also had many milestones at the APA convention. For the first time, we had a hospitality suite program (thanks to Joan Cook and Richard Thompson), and we will continue to expand upon this. We conducted several of our own presentations during the conference itself, co-sponsored others, co-hosted a Town Hall meeting, participated in a presidential thematic program, and maintained a significant presence at the conference. I am also pleased to let you know that our Dessert Reception, which was in conjunction with the Divisions for Social Justice and the Public Interest Directorate, was very popular. In fact we had our largest attendance ever, with nearly 400 people coming to this event. We hope we will be able to keep the tradition going.

As if the above were not enough, we also have numerous task forces working on important projects. The *DSM V task force*, chaired by Terry Keane and Christine Courtois will be a long-term effort to ensure that trauma issues are adequately considered in the future DSM. The *Trauma in the Military and their Families* task force is chaired by Casey Taft, the *Coercive Interrogations and Torture* task force is chaired by Nnamdi Pole (they presented an excellent symposium at the APA convention), and the *Interpersonal Violence* task force is chaired by Sylvia Marotta and co-chaired by Nicole Richardson. Sylvia has been working on the follow up activities from the APA Summit. One of the activities was having Sylvia represent Division 56 at a national think tank that occurred just prior to the International Conference on Violence, Abuse and Trauma in September (see page 4 for her summary). The mission of this think tank was to bring together representatives from several major national organizations, foundations, federal agencies, universities, national movements, consumer groups, and students to establish a blueprint for action in setting a national priority for interpersonal violence prevention. Initial plans were developed for 1-, 3- and 5-year action plans, with follow up meetings in 2009 and 2010. Division 56 was well represented in this think tank, which was co-chaired by Jackie White of Division 35 and myself for Division 56. Other Division 56 Executive Council members (e.g., Sylvia Marotta, Priscilla Dass-Brailsford, Christine Courtois, Casey Taft, and Diane Elmore) also were in attendance representing us or a variety of other organizations or agencies. In addition there will be a biannual APA interdivisional conference on Reducing Interpersonal Violence Across the Lifespan in February 2010 in Dallas, TX. In conjunction with Division 35 and 3-4 other divisions, Division 56 will be one of the lead divisions for this event. All of these events and meetings are coordinated toward the ultimate goals stated above.

A new interdivisional task force has also been appointed to focus on *Ethical Issues in Forensic Cases*

Involving Trauma and Abuse Issues. Co-chaired by Phil Kinsler and Beth Rom-Rhymer, this task force includes representatives from Divisions 37, 41, and 43, as well as from the APA Ethics Committee. Finally, a *Diversity* task force has been appointed to increase diversity in our membership and to ensure that we are dealing appropriately with multicultural issues in all of our tasks and functions. This task force is chaired by Priscilla Dass-Brailsford and will work with the Multicultural Committee and the Membership Committee.

Continued Events for 2009

The Division has various events and emphases that will continue in 2009. It is very important that members include Division 56 in your voting for Council Representative (see page 29). We have a great opportunity to obtain a second Council of Representatives member since we just missed this year. Because this would give us more input into APA governance, please give as many votes as possible to Division 56.

Division 56 will have its next mid-winter meeting at the National Multicultural Summit in New Orleans in January, 2009. This will be another opportunity for Division members to interact with those from other divisions and organizations as we continue to focus on multicultural and diversity issues. Our Special Interest Groups, chaired by Desnee Hall, have also expanded, and we have several active ones already. These allow members to interact with each other based upon mutual areas of expertise and interest, and also help bring new members into the division.

We need to continue to look for new opportunities to raise funds for the Division as we expand our activities. We would also like to increase our program hours at the APA convention. To do so, we need all of you to list Division 56 as your primary division when you register to attend the convention. We are also increasing our interactions with other divisions and organizations where trauma is a key issue. More national and international policies and media issues involve trauma in one way or another, and I look forward to Division 56 being relied upon for developing relevant policies, providing education, and helping to focus attention on the importance of trauma issues for so many people.

Please feel free to provide us with input and ideas. The incoming Board is strong and dedicated, and will continue the solid foundation that has been built for the new division. It has been a pleasure seeing the field of trauma finally take its rightful place in APA and to have a home! I appreciate the opportunity to take part in this endeavor and thank all of you for allowing me to serve the division in its inaugural years.

I look forward to an exciting year for the Division and to meet more of you at one or more of our events next year. Please feel free to contact me (bgeffner@pacbell.net) if you have questions or concerns.

Take care and be safe!

Bob Geffner, PhD
President, Division 56



The Society for General Psychology Division 1 American Psychological Association

Call for Nominations for Awards for Year 2009 Deadline: February 15, 2009

The Society for General Psychology, Division One of the American Psychological Association is conducting its 2009 awards competition, including the **William James Book Award** for a recent book that serves to integrate material across psychological subfields or to provide coherence to the diverse subject matter of psychology, the **Ernest R. Hilgard Award** for a Career Contribution to General Psychology, the **George A. Miller Award** for an Outstanding Recent Article on General Psychology, the **Student Poster Award** and the **Arthur W. Staats Lecture for Unifying Psychology**, which is an American Psychological Foundation Award managed by the Society for General Psychology.

All nominations and supporting materials for each award must be received on or before **February 15, 2009**. There are no restrictions on nominees, and self-nominations as well as nominations by others are encouraged for these awards.

The Society for General Psychology encourages the integration of knowledge across the subfields of psychology and the incorporation of contributions from other disciplines. The Society is looking for creative synthesis, the building of novel conceptual approaches, and a reach for new, integrated wholes. A match between the goals of the Society and the nominated work or person will be an important evaluation criterion. Consequently, for all of these awards, the focus is on the quality of the contribution and the linkages made between diverse fields of psychological theory and research.

Winners of the William James Book Award, the Ernest R. Hilgard Award, and the George A. Miller Award will be announced at the annual convention of the American Psychological Association the year of submission. They will be expected to give an invited presentation at the subsequent APA convention and also to provide a copy of the award presentation for inclusion in the newsletter of the Society (*The General Psychologist*). They will receive a certificate and a cash prize of \$1000 to help defray travel expenses for that convention.

For the **William James Book Award**, nominations materials should include: a) three copies of the book (dated post-2004 and available in print; b) the vita of the author(s); and c) a one-page statement that explains the strengths of the submission as an integrative work and how it meets criteria established by the Society. Specific criteria can be found on the Society's website (<http://www.apa.org/divisions/div1/awards.html>). Textbooks, analytic reviews, biographies, and examples of applications are generally discouraged. Nomination letters and supporting materials should be sent to John D. Hogan, PhD, Psychology Department, St. John's University, Jamaica, NY 11439.

For the **Ernest R. Hilgard Award**, nominations packets should include the candidate's vita along with a detailed statement indicating why the nominee is a worthy candidate for the award and supporting letters from others who endorse the nomination. Nomination letters and supporting materials should be sent to Thomas Bouchard, PhD, Psychology, N249 Elliott Hall, University of Minnesota, 75 E. River Road, Minneapolis, MN 55455.

For the **George A. Miller Award**, nominations packets should include: a) four copies of: a) the article being considered (which can be of any length but must be in print and have a post-2004 publication date); b) the curriculum vitae of the author(s); and c) a statement detailing the strength of the candidate article as an outstanding contribution to General Psychology. Nomination letters and supporting materials should be sent to Donald Dewsbury, WJBA Award chair, Department of Psychology, University of Florida, Gainesville, FL 32611-2250.

The 2010 **Arthur W. Staats Lecture for Unifying Psychology** is to be announced in 2009 and given at APA's 2010 Annual convention. Nominations materials should include the nominee's curriculum vitae along with a detailed statement indicating why the nominee is a worthy candidate for the award including evidence that the nominee would give a good lecture. They should be sent to Harold Takooshian, PhD, Psychology-916, Fordham University, New York, NY 10023.

Candidates for the **Student Poster Award** should submit their poster abstract to the Division One Posters upon call for APA Convention Programs.

General Comments may be made to Dr. MaryLou Cheal, Awards Coordinator, 127 E. Loma Vista Drive, Tempe, AZ 85282.

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.
- » Paper and e-newsletters with timely information on traumatic stress
- » Member-only listserv provides on-going communication with other members and breaking news of trauma-related developments in APA.
- » Voting privileges to elect representatives and participation in the Division's annual meetings.
- » Eligibility to run for office, chair, and serve on Division committees and task forces.
- » Beginning in 2009, all members will receive the new divisional journal, *Psychological Trauma: Theory, Research, Practice, Policy* at the member rate of \$20 per year. You do not need to separately subscribe to receive this journal; just be sure that your dues are paid, and your mailing address is up to date.
- » 30% discounts on Haworth/Taylor & Francis Group journals in the field of trauma

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