



**DIVISION 56**

# TRAUMA PSYCHOLOGY

**AMERICAN PSYCHOLOGICAL ASSOCIATION**

## NEWSLETTER

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### Presidential Voice

#### Moving the Trauma Field Forward

*Bob Geffner, PhD, ABPP, President*

I am very proud to report that the Trauma Division has been approved as a permanent division of the American Psychological Association at their February Council meeting. We sometimes forget that Division 56 has only been a part of APA officially for a little over a year since we have accomplished so much and have already become so intertwined in many APA and interdivisional activities. We also were one of only 12 divisions to increase membership in the last year, and we are still growing!! My goal is 2,000 members by the end of this year. That actually can be accomplished if each of you would commit to bringing in just one colleague as a new member this year. Remember, they do not have to be APA members, or even psychologists, as we build a network of those interested in trauma.

There are many benefits, both collective and individual, to membership in Division 56. Collectively, it gives psychologists and others who are

interested in trauma a home in APA from which to coordinate and influence policy, both within APA and nationally. Individual benefits of membership, which will cost \$45 annually, will now include, after approval at the August business meeting, a \$20 subscription to the forthcoming Trauma Psychology journal, published by APA, as well as



*Robert Geffner, PhD, ABPP, ABPN*

our award-deserving newsletter. In addition, members can get significant discounts to journals from the Haworth Press and Taylor Francis Group (two of these subscriptions save the cost of a year's division membership!).

Laura Brown and her committee are to be congratulated for helping to finalize the arrangements for a division journal. Division 56 was also approved in our first year as the 11th member of Divisions for Social Justice. In addition, as part of our efforts to move the field forward within and outside of APA, we have already appointed five (5) task forces that deal with various trauma issues. Three were appointed in 2007, and two more in 2008. The above are significant accomplishments for a new division.

## Officers

### President

*Robert A. Geffner, PhD*  
Institute on Violence, Abuse and Trauma  
Alliant International University  
6160 Cornerstone Court East  
San Diego, CA 92121  
Phone: (858) 623-2777 x405  
Facsimile: (858) 481-7756  
bgeffner@pacbell.net

### President-Elect

*Steven N. Gold, PhD*  
Professor, Center for Psychological Studies  
Director, Trauma Resolution & Integration  
Program  
Nova Southeastern University  
3301 College Avenue  
Fort Lauderdale, FL 33314  
Phone (office): (954) 262-5714  
Cell: (954) 303-2030  
gold@nova.edu

### Past President

*Judith L. Alpert, PhD*  
Professor of Applied Psychology  
New York University  
239 Greene Street, 5th Floor  
New York, NY 10003  
Phone: (212) 691-6587  
judie.alpert@nyu.edu

### Secretary

*Kathleen Kendall-Tackett, PhD, IBCLC*  
Research Associate Professor of Psychology  
Family Research Laboratory/Crimes Against  
Children Research Center  
126 Horton Social Science Center  
20 College Road  
University of New Hampshire  
Durham, NH 03824  
Phone: (603) 428-8215  
Facsimile: (603) 428-7852  
kkendallt@aol.com

### Treasurer

*Beth N. Rom-Rymer, PhD*  
President, Rom-Rymer and Associates  
180 East Pearson, Suite 3605  
Chicago, IL 60611  
Cell: (312) 961-1735  
docbnrr@aol.com

### Members-at-Large

*Lisa D. Butler, PhD*  
Department of Psychiatry & Behavioral  
Sciences  
401 Quarry Road, Room 2320  
Stanford University School of Medicine  
Stanford, CA 94305-5718  
Phone: (650) 498-5528  
Cell: (650) 714-8787  
Facsimile: (650) 498-6678  
butler@stanford.edu

### *Terry Keane, PhD, Member of Finance Committee*

Associate Chief of Staff for Research &  
Development  
VA Boston Healthcare System  
Research Service (151)  
150 South Huntington Avenue  
Boston, MA 02130  
Phone: (857) 364-4551  
Facsimile: (857) 364-4486  
terry.keane@va.gov

### *George F. Rhoades, Jr., PhD*

Director, Ola Hou Clinic  
98-1247 Kaahumanu St., Suite 223  
Aiea, HI 96701  
Phone: (808) 487-5433  
Facsimile: (808) 487-5444  
rhoades@pdchawaii.com

### Council Representative APA

*Charles R. Figley, PhD*  
Fulbright Fellow and Professor  
Director, Traumatology Institute  
Florida State University, College of Social  
Work  
Tallahassee, FL 32306-2570  
Phone: (850) 644-9598  
Facsimile: (800) 889-0168  
Charles.Figley@FSU.edu

### Professional Affiliate Representative

*Toby Kleinman, Esq.*  
Adler & Kleinman Attorneys at Law  
988 River Road  
Piscataway, NJ 08854  
Phone (office): (732) 878-1170  
Phone (home): (732) 878-1408  
Cell: (732) 309-5952  
Fax: (732) 878-1357  
toby@adlerkleinman.com

### Student Representative

*Patrick Meade*  
Steinhardt School of Education  
New York University  
239 Greene Street  
East Building, 5th Floor  
New York, NY 10003  
pjm269@nyu.edu

## Standing Committees

### Awards Committee

*Terry Keane, PhD, Chair*  
Associate Chief of Staff for Research &  
Development  
VA Boston Healthcare System  
Research Service (151)  
150 South Huntington Avenue  
Boston, MA 02130  
Phone: (857) 364-4551  
Facsimile: (857) 364-4486  
terry.keane@va.gov

### Disaster Relief Committee

*Gilbert Reyes, PhD*  
Associate Dean for Clinical Training  
Fielding Graduate University  
2112 Santa Barbara St.  
Santa Barbara, CA 93105  
Phone: (805) 898-2907  
greyes@fielding.edu

### Diversity and Multicultural Concerns Committee

*George F. Rhoades, Jr., PhD, Co-Chair*  
Director, Ola Hou Clinic  
98-1247 Kaahumanu St., Suite 223  
Aiea, HI 96701  
Phone: (808) 487-5433  
Facsimile: (808) 487-5444  
rhoades@pdchawaii.com

### *Priscilla Dass-Brailsford, EdD, CTS, Co-Chair*

Associate Professor  
Division of Counseling and Psychology  
Lesley University  
29 Everett St. Cambridge MA 02138  
Chair, Committee on Ethnic Minority Affairs  
(APA)  
Co-Chair Multicultural Committee, Division 56  
Phone: (617) 349-8336  
Facsimile: (617) 349-8333  
pdbrails@lesley.edu

### Education and Training Committee

*Anne de Prince, PhD, Chair*  
University of Denver  
Department of Psychology  
2155 Race Street  
Denver, CO 80208  
Phone: (303) 871-2939  
Facsimile: (303) 871-4747  
adeprince@psy.du.edu

### Fellows Committee

*Charles R. Figley, PhD, Chair*  
Fulbright Fellow and Professor  
Director, Traumatology Institute  
Florida State University, College of Social Work  
Tallahassee, FL 32306-2570  
Phone: (850) 644-9598  
Facsimile: (800) 889-0168  
Charles.Figley@FSU.edu

### Finance Committee

*Beth N. Rom-Rymer, PhD, Chair*  
President, Rom-Rymer and Associates  
180 East Pearson, Suite 3605  
Chicago, IL 60611  
Cell: (312) 961-1735  
docbnrr@aol.com

### *Terry Keane, PhD, Member of Finance Committee*

Associate Chief of Staff for Research &  
Development  
VA Boston Healthcare System  
Research Service (151)  
150 South Huntington Avenue  
Boston, MA 02130  
Phone: (857) 364-4551  
Facsimile: (857) 364-4486  
terry.keane@va.gov

### International Committee

*Elizabeth K. Carll, PhD, Chair*  
Independent Practice  
4 Bittersweet Court  
Centerport, New York 11721  
Phone: (631) 754-2424  
Facsimile: (631) 754-5032  
ecarll@optonline.net

### Liaison Committee

*Joyanna Silberg, PhD, Chair*  
Sheppard Pratt Health System  
6501 N. Charles Street  
P.O. Box 6815  
Baltimore, Maryland  
21285-6815  
Phone (office): (410) 938-4974  
Phone (home): (410) 655-8225  
Facsimile: (410) 938-5072  
Jlsilberg@aol.com

### Membership Committee

*Sandra Mattar, PsyD, Chair*  
John F. Kennedy University,  
Graduate School of Professional Psychology  
100 Ellinwood Way, Pleasant Hill, CA 94523  
Phone: (925) 969-3405  
smattar@jfk.u.edu

### Nominations and Election Committee

*Lenore Walker, PhD, Chair*  
Nova Southeastern University  
Center for Psychological Studies  
3301 College Avenue  
Ft. Lauderdale, FL 33314  
Phone: (954) 322-0348  
Facsimile: (954) 322-0397  
Drlewalker@aol.com

### Policy Committee

*Diane Elmore, PhD, Chair*  
Senior Legislative and Federal Affairs Officer  
Public Policy Office  
American Psychological Association  
750 First Street, NE  
Washington, DC 20002  
Phone: (202) 336-6104  
Delmore@apa.org

### Practice Committee

*Christine Courtois, PhD, Chair*  
Christine A. Courtois, PhD & Associates, PLC  
5225 Wisconsin Ave., NW, Suite 513  
Washington, DC 20016  
Phone: (202) 362-2776  
Facsimile: (202) 364-0561  
Home Office and Facsimile: (703) 847-8708  
Courtois@apa.com

### Program Committee

*Joan M. Cook, PhD, Co-Chair*  
Yale University School of Medicine  
Department of Psychiatry  
950 Campbell Avenue; NEPEC/182  
West Haven, Connecticut 06516  
Joan.Cook@yale.edu

### *Richard Thompson, PhD, Co-Chair*

Director of Research  
Juvenile Protective Association  
1333 N. Kingsbury, Suite 306  
Chicago, IL 60622  
Phone: (312) 698-6932  
rthompson@juvenile.org

### Publications Committee

*J. Christopher ("Topher") Collier, PsyD, Chair*  
Steinhardt School of Education  
New York University  
The Park West Practice – Independent Practice  
115 Central Park West, Office 5  
New York, NY 10023  
Phone: (212) 675-2254  
Facsimile: (212) 579-3430  
DrTopherCollier@aol.com

### Science Committee

*Jennifer Freyd, PhD, Chair*  
Department of Psychology  
1227 University of Oregon  
Eugene, OR 97403-1227  
Phone: (541) 346-4950  
Facsimile: (541) 346-4911  
jif@dynamic.uoregon.edu

### Special Interest Groups

*Desnee Hall, PhD, Chair*  
Private Practice  
7 Weyburn Road  
Scarsdale, NY 10583  
Phone: (914) 472-9848  
Desneehallphd@aol.com

### Student Affairs Committee

*Patrick Meade, Chair*  
Steinhardt School of Education  
New York University  
239 Greene Street  
East Building, 5th Floor  
New York, NY 10003  
pjm269@nyu.edu

### Newsletter Editor

#### TRAUMA PSYCHOLOGY NEWSLETTER

*J. Christopher ("Topher") Collier, PsyD*

Steinhardt School of Education  
New York University  
The Park West Practice – Independent Practice  
115 Central Park West, Office 5  
New York, NY 10023  
Phone: (212) 675-2254  
Facsimile: (212) 579-3430  
DrTopherCollier@aol.com

### Web Master

#### www.apatraumadivision.org

*Laura Brown, PhD*  
4131 1st Avenue NW  
Seattle, WA 98107-4910  
Phone: (206) 633-2405  
lsbrownphd@cs.com

### Listserv Manager

*Preetika Pandey Mukherjee, MS*  
New York University  
Department of Applied Psychology  
30 River Road, Apartment 11K  
New York, NY 10044  
Phone: (212) 219-0798  
pp457@nyu.edu

### Task Force on Role of Psychologists in Interrogations from the Perspective of Trauma Psychology

*Nnamdi Pole, PhD, Chair*  
Department of Psychology  
University of Michigan  
2260 East Hall  
530 Church Street  
Ann Arbor, MI 48109-1043  
Phone: (734) 763-4132  
Facsimile: (734) 615-0573  
nnamdi@umich.edu

### Task Force on the Military and Their Families

*Jaine L. Darwin, PsyD, Chair*  
1619 Massachusetts Ave.  
Cambridge, MA 02138  
Phone: (617) 354-7480  
Facsimile: (617) 354-7430  
jldarwin@aol.com

### Task Force for Monitoring and Providing Feedback Concerning Trauma in DSM-V

*Terry Keane, PhD, Chair*  
Associate Chief of Staff for Research &  
Development  
VA Boston Healthcare System  
Research Service (151)  
150 South Huntington Avenue  
Boston, MA 02130  
Phone: (857) 364-4551  
Facsimile: (857) 364-4486  
terry.keane@va.gov

# 2008 Division 56 APA Convention Program

## Exciting Times for Trauma Psychology

Joan M. Cook and Richard Thompson  
Program Committee Co-Chairs

### APA Annual Convention, Boston, August 14–17, 2008

This is our second year of full programming at the APA conference and it should prove to be very exciting with a broad range of innovative research and clinical endeavors. Highlights from the Division 56 program include:

*Project Fleur-de-lis: Collaborative Behavioral Therapy Efforts Addressing Trauma in Children*—This symposium, chaired by Dr. Baraka Perez, features presentations by members



Joan M. Cook, PhD

of Project Fleur-de-lis, a school-based mental health program, designed to promote recovery for children and their families in the aftermath of Hurricane Katrina. This presentation will include a description of the program, recent outcome findings, and lessons that can be adapted to other programs that intervene with children and communities that have encountered disasters. The creation of this program was presented at last

year's APA conference, and this year's presentation will update members with outcomes and lessons learned.

*Ending Long-Term Trauma Psychotherapies: Clinical and Ethical Considerations*—This discussion, co-sponsored by Division 29 (Psychotherapy), and chaired by Dr. Karen Saakvitne, explores the very real issues clinicians face when ending long-term therapy with trauma survivors. While much of the clinical literature and training focus on the beginning of therapy (e.g., assessment, establishing alliance). This presentation focuses on issues such as risk management and ethical considerations, and suggests ways of negotiating this often-difficult process of ending long-term therapy with trauma survivors.

*The Aftermath of the Virginia Tech Shootings: Distress and Resilience*—This symposium, chaired by Heather Littleton, presents emergent research conducted on the immediate aftermath of the tragic shootings at Virginia Tech University. The research examines informal help-giving processes in response to the shootings, and predictors of anxiety and quality of life as well as trauma symptoms in students. In addition, prospective research will be discussed, allowing a unique opportunity to more fully understand responses to such tragedies and the important role of pre-trauma functioning.

Perhaps no issue has been more controversial in recent times than that of the role of psychologists in national security interrogations. A symposium, chaired by Dr. Robert Geffner, *Discussion of Trauma-Related Issues in National Security Interrogations*, will examine this issue. It will provide an opportunity to hear the thinking of key psychologists, such as Dr. Nnamdi Pole, on the ethical issues around interrogations and provide the opportunity to continue the discussion of the role played by psychologists.

We also want to bring your attention to the other elements of the rich and varied convention program that will be sponsored by Division 56 at this year's Annual APA Convention. For dates, times and locations of these events, see the accompanying *Division 56 Convention Program Preview* on page 20.

In addition to the symposia and discussion session listed above, Division 56 will include six additional symposia. These sessions will address a range of topics on trauma research, practice, theory and training:

One important symposium will examine *Trauma and Refugees: Recent Advances in Science & Practice*, chaired by Dr. Meredith Charney. This discussion will examine specific issues frequently faced by traumatized refugee populations, including HIV-AIDS and torture. As well, it will examine clinical interventions for youth refugee populations, including youth from Somalia and Uganda.

Posttraumatic growth is frequently discussed, but remains poorly understood. The symposium *Conceptions and Misconceptions of Posttraumatic Growth*, chaired by Dr. Lawrence Calhoun, will examine some common misconceptions about posttraumatic growth and distinguish it from common cognitive distortions. It will also examine the role that culture plays in the expression of post-traumatic growth and legal issues surrounding the concept.

A panel led by Dr. Cheryl Gore-Felton will present the symposium *Trauma and HIV/AIDS: Implications for Clinical Care, Prevention and Research*. This symposium will present research on links between various traumatic experiences and HIV risk behavior, coping with HIV diagnosis, and quality of life.

Division 12 (Clinical Psychology) is co-sponsoring a symposium, *Commonalities and Divergences in Dissociation across Various Populations*. This symposium will be chaired by Dr. Jan Faust and will examine some thought-provoking issues in dissociation, looking at three difficult contexts: sexual abuse and family conflict, the presence of dissociation in forensics, and combat stress injuries.

Another provocative symposium will examine the issue of *Risk Factors for Sexual Victimization: Implications for Treatment and Intervention*, chaired by Dr. Christine Gidycz. This symposium will examine some of the issues underlying the discouraging results of sexual assault risk reduction programs for women. It will include presentations examining previous victimization history, perceptions of risk, sexual attitudes, and the context of violent relationships. It will also include an examination of intervention for women who have been sexually victimized.

The new Dissociation Special Interest Group (SIG) will present a symposium, *Dissociating Dissociation: Views from the Trauma Psychology Dissociation SIG*. This is a great opportunity



Richard Thompson

to hear from experts in the field of dissociation. It will be chaired by Dr. Harold Siegel.

For those seeking to expand their clinical expertise in trauma psychology, particularly with children, two workshops will be offered. One, chaired by Dr. Athena Drewes, is *Effectively Blending Play-based Techniques with CBT Child Sexual Abuse Treatment*. This workshop will describe the rationale for using play-based techniques with this population and will present some examples of specific techniques and their application to children who have been sexually abused. It will also review the evidence for the efficacy of integrating play-based techniques in therapy. Another workshop, chaired by Dr. DeDe Wohlfarth, is *Sexually Reactive Behavior in Young Children: Theory Informing Treatment*. This workshop will present evidence on the link between sexual abuse and sexually reactive behavior, leading into a presentation of assessment and intervention techniques.

A key problem facing trauma researchers, is recruiting representative samples, and, in the case of longitudinal research, retaining them over time. The discussion *Recruitment/Retention in Trauma Research: Meeting the Challenge of Special Populations*, chaired by Dr. David Meyer, will examine the general issues of recruitment and retention, using the insights gained from work with three special populations exposed to trauma: firefighters, veterans of the Iraq and Afghanistan wars, and refugee children and their families.

A paper session titled *Trauma in Diverse Populations* will bring together research on trauma in three disparate populations. Dr. Minal Bopaiah will discuss *Reactions to Torture: Comparing Punjabi and Tibetan Survivors*. In *Poverty, Educational Attainment, and Partner Abuse of African American Mothers*, Dr. Thema Bryant-Davis will examine the complex interplay between these risk factors. And in *Criminal Offending History in Male Veterans with SUD and PTSD*, Dr. Christopher Weaver will examine the association between these symptoms and criminal offending.

A second paper session, *Trauma Treatment Interventions*, will focus on clinical issues with different populations. *Child and Family Traumatic Stress Intervention: Preliminary Evidence of PTSD Prevention*, presented by Dr. Carla Stover will provide initial evidence for prevention of a family-based intervention. *Real Life Heroes: Attachment-Centered Treatment for Children with Traumatic Stress*, presented by Dr. Richard Kagan, will focus on an intervention approach for treating children who have been victims of family violence. Finally, *Virtual Iraq: VR PTSD Exposure Therapy with Iraq War Combatants*, by Dr. Albert Rizzo, will present preliminary data on a novel approach to treatment of veterans exposed to combat.

Finally, a third paper session, *Neurocognitive Functioning in Traumatized Populations*, will examine some research in this developing area. It will include the following presentations: *Relationship Among Mental Health, Trauma, Dose, Types and Profiles, and IQ: The Case of African American and Iraqi Refugees* by Dr. Ibrahim Kira, *Neurocognitive Functioning in Young Adults Exposed to Childhood Interparental Violence* by Dr. Carryl Navalta, and *Exposure to Violence and Cognitive Functioning in Ethnic Minorities* by Dr. Rafael Javier.

As part of the APA presidential initiative, Division 56 and Division 35 (Society for the Psychology of Women) are co-sponsoring a special town hall meeting, *Reducing Interpersonal Violence—Planning for the Future*. This event will be chaired

by Dr. Alan Kazdin, APA president, and include talks by Drs. Robert Geffner, president of Division 56, and Jackie White, president of Division 35.

In addition, the Division 56 program will include two poster sessions. One entitled *Trauma-related Assessment and Treatment* consists primarily of practice-relevant research. The other, *Special Populations and Special Issues*, is mainly comprised of research and clinical work examining the relation of trauma exposure to various psychological processes and in various demographic sub-groups.

On Friday, August 15<sup>th</sup> from 8 to 10 pm, there will be a *networking and awards dessert reception* hosted by Division 56 with the Public Interest Directorate and Divisions for Social Justice. This opportunity to socialize and share ideas is co-sponsored by Taylor & Francis Publishers.

Finally, a highlight of our program this year is likely to be the presidential address by Dr. Robert Geffner, *The Traumatic Effects of Violence and Abuse in Relationships*. This address will take place on Saturday, August 16<sup>th</sup> at 4 pm, followed by the Division business meeting at 5 pm.

Rounding out this full program will be events still in the planning stages to take place at the *Division 56 Hospitality Suite*. Books authored by members of Division 56 will be on display at the hospitality suite, and organizational meetings for the Division's SIGs will be held there. As well, there will be a students' brownbag meeting in the suite, as well as a special meeting to discuss diversity issues in trauma psychology. We hope to see you at the *Division 56 Hospitality Suite*, as well as at many of the other components of the rich and varied convention programming that Division 56 will be offering.

This is the third year of Division 56's existence and our second year of eligibility for full programming. In looking at the quality and scope of the convention events our division has assembled this division has a lot to be proud of, particularly given the newness of the division. As program co-chairs, we are grateful to Division governance, the many contributors who submitted quality presentation proposals, and the large and energetic panel of reviewers who made our work so much easier than it otherwise would have been. As a division, we have much to be optimistic about, a great deal to celebrate, and an extremely exciting convention to look forward to in August. *See you in Boston!*

## Division 56 Election Results

**President-Elect:** Laura Brown  
**Member-at-Large:** Harriette W. Kaley  
**Professional Affiliate Representative:**  
David Albright

Please join me in congratulating our newly elected officers!

Judie Alpert, Chair, Nominations and Elections  
Committee of Division 56

## Remembering Bill

Judith L. Alpert  
New York University

*The following is a brief introduction to the paper I presented at the American Psychological Association Summit on Violence, February 29, 2008, Bethesda, Maryland*

I have never forgotten Bill. He was my patient in psychoanalytically oriented psychotherapy over 20 years ago. He was happily married and had two children. Work was going well for Bill also as he had a secure, creative position in an advertising firm.

As I listened to him, I kept wondering what was bringing him into treatment. Nothing seemed wrong with his present life. Slowly he told me about the demons from the past and how he knew it was important to confront them in some way.

His demons: he never knew his father, and his mother was a drug addict who brought men home to their studio apartment and who paid her for, as he put it, "services." Meals and, often, food, were not routinely a part of his life. At the age of seven, he felt responsible for feeding his younger siblings, ages 5 and 3. He did this by stealing food from the school cafeteria and prostituting himself on New York City's 42nd Street. He told me that social services were never involved with his family and that he somehow limped along in this way until he got a scholarship and went to college.

We talked a lot about how well he was doing, especially in light of his history. I wondered aloud, for example, how he learned to be such a caring father who would read to his children and build sky scrapers with them when no one did that for him. He then told me about his teachers. They were dogs. Yes, literally, dogs. While hanging out on 42nd Street, he would see parent dogs

caring for baby dogs and stray dogs caring for each other. He watched them. He studied them. In this way he learned about caring, kindness and empathy.

I mention this story in the context of gaps in knowledge. I have never read a study indicating the pedagogical skills of dogs. I am not suggesting a new tool for parent training. Rather, by this brief narrative, I am pointing to what we all know: some kids fall through the cracks, and some kids survive by means we know little about.

I wonder as well if there were teachers or other school staff who knew about Bill's life. If no one did, why didn't they? And if they did know, why wasn't he helped early on? School was the one and only institution which had regular contact with Bill.

While Bill survived his horrific childhood, many neglected or abused children do not survive. Abuse and neglect are destructive to both children and families. The statistics are staggering. The estimate is almost 3 million for the true incidence of children at risk of harm from abuse and neglect. The financial costs of child maltreatment to society are staggering as well.

Secondary and tertiary prevention are important and need to continue. Bill's case, however, exemplifies how secondary and tertiary prevention can fail.

We need more primary prevention programs. It may be that Bill would not have had to study the caring, kindness, and empathy of dogs, if either of his parents had been the recipient of primary prevention intervention.

We need to make schools the central place from which preventive services are offered. We need to work in schools and train pre-parents and parents about parenting. To do this, we need to train the next generation of psychologists about child abuse and neglect and we need to expand the practice of our profession to include primary prevention of child maltreatment.



Judie Alpert, PhD

## APA Summit on Violence and Abuse in Relationships: Connecting Agendas and Forging New Direction

Summary by Sylvia Marotta



Sylvia Marotta

Approximately 450 participants, 19 APA divisions, and 14 agencies, organizations and other groups came together in Bethesda, MD, around the topic of violence and abuse in relationships at the APA Summit held on February 28<sup>th</sup> and 29<sup>th</sup>, 2008. Conceived and organized as part of APA President Alan Kazdin's presidential initiatives, the Summit was Co-Chaired by Jackie

White, President of Division 35 (Society for the Psychology of Women) and our own Division 56 President, Robert Gefner. The purpose of the event was to provide a forum for multidisciplinary researchers, practitioners, policy makers, and consumers to share agendas and define a direction for reducing and eliminating violence in our society. The summit was a stimulus for many other initiatives on violence that will unfold in the next few years, including a think tank, a mini-convention at APA in Boston, and a biennial summit on the issue.

The Summit was structured to provide maximum inclusion of participants through a legislative advocacy

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# APA Summit on Violence and Abuse in Relationships

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afternoon, an evening poster session, plenaries, small group sessions, and a town hall meeting. Speakers presented their concepts of what is currently known about violence and abuse in relationships, what the gaps are in our knowledge, and what we can do to address these gaps. Participants discussed their interests and experiences in research, intervention, and prevention in reaction to what they heard from plenary speakers. By encouraging participants to engage around the speakers' presentations, a dialectic developed that should continue to foster innovative thinking that can reduce this major public health problem.

To illustrate the flow of the summit, and the multidisciplinary nature of its focus, one of the two opening plenary speakers was a microbiologist who is now Deputy Assistant Secretary for Health at the U.S. Department of Health and Human Services, Dr. Wanda Jones. Dr. Jones asked whether participants were soaring, gliding, or diving on the issue of violence and abuse in relationships. Her question challenged participants to reflect on our roles and potential contribution to effective social interactions. Social worker and consumer advocate Jacki McKinney challenged participant researchers and practitioners alike to hear the voices of clients and consumers and to form partnerships to shape research questions and recovery planning. Ms. McKinney is the Director and co-founder of the National People for Color Consumer/Survivor Network and specializes in African American family advocacy.

Subsequent plenary speakers on Friday included sociologist David Finkelhor, Co-director of the Family Research Laboratory at the University of New Hampshire, epidemiologist Ann Coker, Verizon Wireless Endowed Chair

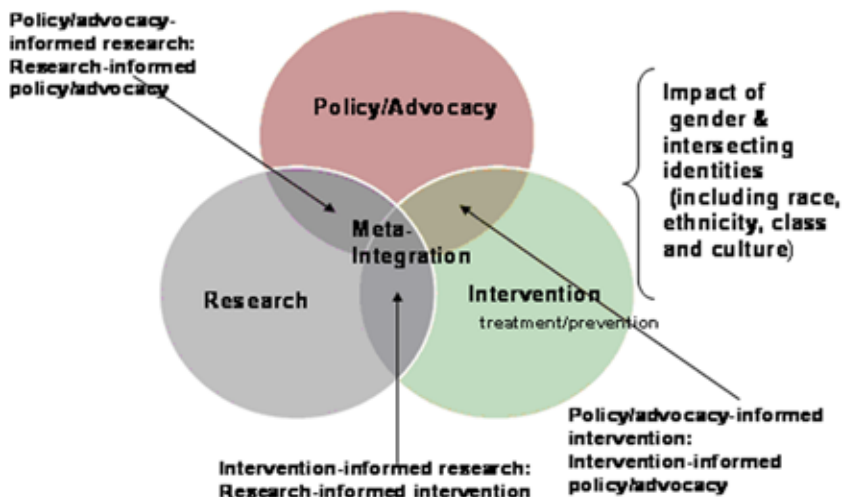
of Studies on Violence Against Women at the University of Kentucky School of Medicine, and psychologists Mary Koss, Regents' Professor in the Mel and Enid Zuckerman Arizona College of Public Health, and Rodney Hammond, Director of Violence Prevention, National Center for Injury Prevention and Control at the Center for Disease Control and Prevention. Dr. Finkelhor took a 20 year perspective on various forms of interpersonal violence, providing some hope that while there is still much to do to reduce violence rates, some forms of family violence, such as child abuse of various types, rapes, and homicides have declined since the early 90s, in some cases significantly so. Dr. Coker provided some thought-provoking generational linkages between and among childhood abuse and future intimate partner violence perpetration or victimization. She suggested that prevention may need to be tailored by gender, and that cross disciplinary intervention is required to address relationships between bullying and later sexual aggression. Dr. Koss reviewed policy recommendations over the 16 years ending in 2006, and noted that among the 85 distinct recommendations, prevention and advocacy had the most consensus; she also surveyed Summit participants to determine their perceptions of progress and future recommendations. Dr. Hammond gave many examples of CDC efforts at reducing and preventing such public health threats as teen dating violence and sexual violence.

Following the plenary sessions, participants were invited to select from 24 breakout sessions. Division 56 members were well-represented as speakers. Past President Judie Alpert presented the state of our knowledge base on primary prevention of child maltreatment, and encouraged school-based platforms from which to launch preventive services and conduct research. A panel presentation by Christine Courtois, John Foubert, and Angela Rose discussed issues pertaining to sexual violence among adult groups. Problems in the current conceptualization and diagnosis of posttraumatic stress disorders in the complex or extreme category, sexual violence on college campuses, and advocacy from grassroots survivors of such campus violence, provided fertile discussions among session participants. Martha Banks presented an overview of research on risks for abuse experienced by women with disabilities, providing a variety of strategies for this group where research is very much in nascent stages. A session on special populations, including South African youth with a history of experiencing political and community violence, prevalence rates and risk



Priscilla Dass-Brailsford presenting at the Summit on *Effects of Community Violence with respect to Special Populations*

## New Perspectives on Integrating Research and Practice



factors faced by immigrants from the Caribbean and Africa to the United States, and trauma among military families, was presented by Priscilla Dass-Brailsford, Thelma Bryant-Davis, and Casey Taft, respectively.

The Summit sessions helped participants to examine the intersections of research-informed policy and practice-informed research. The figure on the previous page, created by Jackie White and Bob Geffner, illustrates some of these new perspectives on ways to connect agendas and break down the silos of the respective disciplines represented at the meeting.

The Thursday evening session contained a total of 85 poster presentations organized during a reception. Chaired by Tom Sexton, a committee selected posters that were a representation of how the next generation of researchers is being mentored. Providing a multigenerational view of the research base on violence and abuse in relationships, senior researchers, as well as graduate students doing their first poster presentation, covered the gamut of age groups, comorbidities, and potential settings in their explorations of current research. Such diversity in content and in presenters promises future directions for research that will help narrow the gaps in our knowledge base on this critical social and public health issue.

A town hall meeting closed the Summit by presenting short summaries of roundtable discussions by participants.

The purpose of these discussions was to generate ways to connect the agendas of the various groups represented, and to determine a path towards future work for conference presenters to use in planning. Some themes heard at the town hall meeting included: the need for training and education on violence infused into curricula of the various disciplines; the need to involve the media more effectively and through targeted interventions advertised to the public; the creation of a national advocacy project constructed along the lines of Mothers Against Drunk Driving (MADD); and ways to involve consumers at every level of our newly integrated models. Division 56 will continue to be involved as these suggestions crystallize in the next year.



*Christine Courtois presenting at the Summit on Adult Survivors of Sexual Victimization and Complex Trauma*

## New Resource on Trauma Studies Available

The University of Oregon (UO) Department of Psychology and the UO Libraries have teamed up to create an important new digital collection of ground-breaking medical and scientific literature in the field of dissociation and trauma. Dissociation & Trauma Archive (<http://boundless.uoregon.edu/digcol/diss/index.html>) contains the full text of many articles appearing in key journals published between 1862 and 1922.

“The early history of trauma studies is of critical importance to contemporary research,” says Jennifer Freyd, professor of psychology at the UO and Head of the Division 56 Science Committee. “By reading historical reports and analyses of childhood trauma from the past, we can discover not only how trauma impacts children and the adults they become but also how the cultural and historical context molds our approach to questions and issues about this condition.”

Freyd also notes that “an interesting aspect of the digitized articles is that they describe and document phenomena we study now but they do so with a very different conceptual framework. For instance, many of the descriptions of what we now call dissociative identity disorder do not assume a trauma etiology. Many of the authors of the old works were explicitly searching for explanations of the phenomena and in some cases come up with some ideas that seem very odd to us today. We know now that trauma is strongly associated with dissociative disorders. Furthermore a lot of controversy today about dissociative phenomena is connected with controversy about trauma, particularly child abuse. It even seems that some skeptics question the reality of dissociative identity disorder in part because of the trauma framework. The old articles show that people did observe dissociation, even without a trauma perspective.”

The articles in the archive include several from early French publications. The text of the articles is fully searchable, and the archives can be browsed by article title, journal, and author. Additional articles will be digitized and added to the archive over the next few months.

Several links to more recent journals and specialized resources are also provided, including all articles published from 1988 to 1997 in the seminal journal, *Dissociation: Progress in the Dissociative Disorders*, along with links to material related to the life and work of Pierre Janet, an early pioneer in the field of trauma studies.

Dissociation and Trauma Archives was developed in part during a graduate psychology class, Childhood Trauma, taught by Freyd. Frank Putnam, MD, was also a major contributor to the project.

Barbara Jenkins, head of reference and psychology subject specialist for the UO Libraries, worked closely with Freyd to identify and access the materials for the archives. “These historical resources in a specialized area such as dissociation and trauma are often scattered and difficult to locate,” Jenkins says. “I was drawn to the challenge of helping Freyd and her students locate the items and assess their suitability for inclusion in the archives. The involvement of the graduate students in the process facilitated the development of the resource and enhanced their research experience.”

Karen Estlund, the library’s digital collections coordinator, and other members of the library’s Metadata Services and Digital Projects staff digitized the content and developed the interface for the archives. The library hosts the archives as part of its Digital Collections, making it available online to a global community of students and researchers.

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# Textures of Suffering: PTSD and Its Socio-Cultural Context

Sandra Mattar, PsyD

*Trauma and its psychic aftereffects have a texture. The experience conveys meanings that derive from personal histories, cultural heritages, and the social, political, and spiritual contexts in which the painful event happens (Brown, 2008).*

Hooda (not her real name) is a 35-y.o. Afghani woman who came to see me a few years ago for her symptoms of Post Traumatic Stress Disorder (PTSD). She witnessed the murdering of her husband and brother-in-law during the war in Afghanistan. They had been killed by the Taliban due to their political views. Hooda was also raped while on her way to a refugee camp in Pakistan. Moreover, she was experiencing added stress due to her recent immigration to the United States, as well as her status as an unemployed refugee and single mother of a 15-y.o. son and a 10-y.o. daughter.

The first cultural misunderstanding in my work with Hooda occurred when we talked about our goals for therapy. Looking at me in disbelief she said: “How can you predict what is going to happen in a few months? I can’t do that! Only God knows.” My second clash occurred when I encouraged her to tell me about her traumatic experiences before she immigrated to the U.S. Hooda refused to do that on the grounds that remembering will make her “crazy.” I encouraged her to tell her story because I thought we had developed enough trust in our relationship for her to feel safe to do so. Hooda just wanted to be medicated to calm down her anxiety and somatic pain. She also needed some medication that would allow her to sleep.

Retelling her story could prove to be fatal for her and her children because “someone could find out and hurt them.” Unbeknownst to me, there were several political factions among the Afghani community in her U.S. small town and gossip was very prevalent in the community.

Everything that my Western trauma training had prepared me to do with clients suffering from PTSD was almost useless with Hooda. Instead of focusing on managing her PTSD symptoms, she wanted to work on her role as a single mother who was facing rebellious children who only wanted to “eat American food” and behave in “American ways”. As she said this to me while sitting on the carpet in her living-room, her son, wearing aviator glasses, insisted that I call him “J.J.” instead of using his Afghani name. Hooda was haunted by the idea that she could not fulfill her role as a mother if she was not preparing Afghan foods for her children. Her whole sense of identity was tied to her cooking and maintaining cultural traditions. In fact, preserving her Afghan culture and keeping traditions alive were more important and effective as a treatment intervention than helping her to identify traumatic triggers. Talking about her past traumas represented giving up to the perpetrator and her husband’s assassins. Disclosing also felt very selfish to her since her identity was tied to her children’s and talking

about past traumas “would not help them.” Hooda’s way of communication was through somatic complaints. Using an individualistic/narrative approach to treat her proved to be futile.

Our work together focused on supporting her in her role as a newly arrived immigrant in this country: job searching, bridging the acculturation gap between mother and children, encouraging leisure activities with fellow Afghans, increasing physical self-care such as reducing her extreme caffeine intake, as well as taking care of her body through relaxation exercises. I also encouraged her to use her Muslim religious beliefs and prayers as a way to relax.

Hooda’s story is typical of trauma work with non-Westerners. Therapy’s course and outcome can be unpredictable. As Abi-Hashem (2008) indicates: “relying on theories and clinical approaches developed in the West and for Western use can be utterly unhelpful, irrelevant, and, at times, counterproductive for many groups” (p. 156). While many of these clients do show symptoms consistent with our Western notion of PTSD which create a significant impairment, the way they conceptualize and express their symptoms has a very unique texture determined by that person’s culture. This unique texture is what Kleinman (1988), one of the founders of cultural psychiatry, called the Explanatory Belief Model. In his book “Rethinking Psychiatry” (1988), Kleinman encouraged mental health professionals to understand the personal meaning behind suffering as well as the context of suffering. He emphasized the fact that “culture creates alternative channels for communicating and distinctive idioms for expressing negative feelings” (p. 24). These are not areas traditionally associated with the biomedical model. According to Kleinman, body pains are understood as metaphors for social, moral and political problems. It would make sense, then, that a rational and verbal approach would not be relevant as a therapeutic intervention with Hooda. Instead, a body-oriented approach complemented with socio-cultural interventions aimed at addressing the terrible disruptions of communal life using sewing and dance groups, would be more helpful.

Wilson, Friedman and Lindy (2001, in Marsella et al, 2008)) remind us that we cannot assume that Western, scientifically validated treatment for traumatized individuals are helpful with non-Western individuals: “The extension of Western PTSD practices to non-Western people must be done with great care and sensitivity” (p. 354). In fact, no matter how strong the “evidence” in favor of certain treatments for trauma is, it can become irrelevant when working with non-Westerners. No currently available evidence-based treatment can capture the complexity of Hooda’s life and her socio-political context, as well as the reasons for not wanting to share her story with her therapist. The lack of culturally-sensitive trauma treatments is a significant fact given our frantic search for evidence-based



Sandra Mattar, PsyD

*continued on p. 10*

## Textures of Suffering

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treatments. A natural question that stems from this line of inquiry is the need to deconstruct what evidence means, and who defines what this evidence is.

There is no doubt that extant Western efforts to alleviate human suffering are worthwhile, but this is true only if we are willing to understand that the meaning of suffering is culturally-bound as well as socially embedded. The way we do this integration, in Kirmayer's (2007) words, is to adopt new ways of listening, discarding arrogant assumptions of universality, and considering explanations of context and meaning. Brown (2008) states that "responding to trauma in a culturally competent manner requires the psychotherapist to understand how those added meanings deriving from context and identity make each instance of trauma unique" (p. 5)

In thinking back about my work with Hooda, I remember how eager I was to apply all the knowledge I had

acquired in my trauma-focused clinical training. The trauma models I had learned seemed infallible. Hooda taught me that the so-called empirical models, the bastions of scientific practice, were much more limited than they had been touted.

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## TRAUMA AND HEALTH Health Care Can Change From Within: A Sustainable Model for Intimate Partner Violence Intervention and Prevention

Bruce Ambuel, PhD

Department of Family and Community Medicine  
Medical College of Wisconsin

L. Kevin Hamberger, PhD

Department of Family and Community Medicine  
Medical College of Wisconsin

**C**ase—Part 1. KC is a 50-year-old woman, assaulted 3 weeks ago at a family gathering by her husband who became angry with her then punched and strangled her, causing her to fear for her life. Although he was arrested and remains in jail, KC continues to feel unsafe. She sees her family physician reporting "I'm having problems sleeping, feeling stressed all the time, and depressed." Because she feels embarrassed and guilty about what happened, she does not mention the assault to her physician or nurse.



Bruce Ambuel, PhD

### Introduction

Intimate partner violence (IPV) is a significant cause of morbidity and mortality (Hamberger & Phelan, 2004; WHO, 1996). Battered women

are at increased risk of depression, anxiety, PTSD, injury, disability, smoking, drug abuse, alcohol abuse, sexually transmitted infections, elective abortion, asthma, gastrointestinal disorders, and headache. They receive less preventive medical care, and more medical care for episodic problems. They are hospitalized more often for all causes. In recognition of these health consequences, many medical societies recommend asking all female patients

about IPV as part of routine health screening. Still, health care providers frequently fail to identify IPV, or fail to offer appropriate primary and secondary prevention services.

Much research progress has been made since 1990 toward improving the health care response to IPV. Women patients want physicians to ask about IPV, and view physicians as a trusted source of information and support. We can reliably identify women who are in abusive relationships using specific, brief screening questions. We can improve practitioner's knowledge, attitudes and clinical skills through professional education. Recent studies suggest that we can reduce future violence and improve health for battered women using brief clinic and community based advocacy. At a systems level, we can produce temporary improvements in the clinical care provided to victims of IPV, but these improvements dissipate over time (McLeer, Anwar, Herman, & Maquiling, 1989; Minsky-Kelly, Hamberger, Pape, & Wolff, 2005). No studies have demonstrated comprehensive, sustained improvement in the health care response to IPV.



L. Kevin Hamberger, PhD

### Health Care Can Change From Within

Our goal in the Change from Within project is to create sustained improvement in a clinic's or emergency department's response to IPV. The model employs proven educational interventions and quality improvement strategies. The model goes beyond prior work by seeking to change the culture of the medical clinic and health care organizations so that IPV intervention and prevention

is sustained and institutionalized. The ultimate goal is improving the health of women who are experiencing IPV. The Change from Within model has five components:

#### *Component 1: Train health care advocates at each clinic.*

Health care advocates are an innovative, essential element of the Change From Within model. Each clinic recruits 2 or more staff members who participate in an intensive 20 hour training program on IPV and health care. The Advocate's role is to support the training of other clinical and office staff in IPV prevention, and support the clinics' implementation of primary and secondary IPV prevention. Primary prevention includes selecting, displaying and distributing patient education materials about IPV and healthy relationships. Secondary prevention includes design and implementation of clinical protocols for physicians, nurses and other staff to identify and help patients who are current or past IPV victims. Advocates work with clinic committees, physicians and administrators to develop or revise policies and procedures, and implement continuous quality improvement initiatives to monitor clinical outcomes. The Health Advocate responsibilities are integrated into their job description by the clinic manager so that the clinic makes an organizational commitment of leadership which continues into the future. Because of their training and expertise, other staff will approach Health Advocates for advice and consultation regarding patients who are experiencing IPV. Advocates may also work directly with a patient in crisis.

#### *Component 2: Train all clinic staff.*

Health care advocates help organize training programs for all clinical and administrative staff. These educational programs are run by professionals experienced in the health care response to IPV. Topics include knowledge, attitudes and behavioral skills relevant to each staff person's respective clinic roles (see Ambuel, Hamberger, & Lahti, 1997).

#### *Component 3: Change clinical systems.*

Primary care clinics and emergency departments are complex organizations where staff members often fulfill multiple roles with competing time demands, placing a premium upon efficiency during periods of peak workload. Within this environment, physicians, nurses or other staff can only implement and sustain changes in clinical care if there are corresponding clinic system changes which allow them to do so. A team approach is required in which all team members have similar expectations and desire similar outcomes, and where the clinic system—workflows, policies and procedures—is organized to achieve and sustain these outcomes.

Clinics implementing the Change from Within model develop local solutions to meet local needs. These systemic changes are expected to achieve: (1) Secondary prevention of IPV by consistent identification of victims of intimate partner violence, and appropriate intervention; (2) Primary prevention of IPV through patient education about IPV and healthy relationships; (3) Continuing education for professional and office staff, including annual programs and

training of new staff; (4) Continuous quality improvement to measure change in outcomes, and improve clinic response; and, (5) Adoption of written policies and procedures.

#### *Component 4: Partner with individuals and women's advocacy organizations.*

Partnership and collaboration with individuals and organizations in the community is fundamental to the Change From Within model. Key partners include local women's advocacy organizations, and health care professionals with expertise in IPV prevention. Health care IPV prevention experts offer high quality training and consultation to the health care clinic. The women's advocacy agency provide important resources and support for clinic patients including emergency shelter, counseling, support groups, legal advocacy, transitional living and career planning.

#### *Component 5: Change the clinic's organizational culture.*

The overarching goal of the Change from Within model is to transform clinic organizational culture so that IPV prevention is integrated and becomes routine. Organizational culture refers to two facets of the medical clinic—a network of meaning, and material elements of culture. Examples of the network of meaning include knowing that IPV has serious immediate and long-term health consequences, believing that IPV is preventable, and valuing an interdisciplinary team approach by physicians, nurses and other clinic staff. Examples of the material elements of culture include health history forms which inquire about violence and abuse, nurses and physicians routinely asking patients about IPV, forms in the medical record which efficiently organize the data relevant to IPV screening, history and intervention. Material elements of culture also include display of posters and brochures about healthy relationships and domestic violence, written policies and procedures.

### **Evaluating the Change From Within Model**

We are currently evaluating the Change from Within model at two family medicine clinics, a pediatrics clinic and an emergency department. Our evaluation strategy focuses on three levels of analysis—individual clinic staff, the health care clinic culture, and female patients who are IPV victims. We expect that physicians will show a demonstrable improvement in behavioral skill in carrying out IPV prevention tasks, and increases in IPV attitudes and knowledge. We expect clinics to show sustained improvements in IPV prevention, including written policies and procedures that describe the clinic's planned response to IPV, patient education through posters, brochures and discussion, use of clinical protocols for prevention; screening, intervention, and documentation, chart tools such as body injury maps, interview chart prompts and patient health surveys that will support efficient work by physicians and nurses, and evaluation of clinical indicators with feedback to clinicians on their individual performance. Finally, we expect patients who are victims of IPV to experience less violence, illness and injury, report higher levels of health and well being, and report greater connection to the community.

*continued on p. 12*

## Health Care Can Change From Within

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*Case—Part 2.* The clinic KC visited recently implemented the Change from Within model. Following the new clinic protocol, the nurse asked KC about IPV, and KC responded affirmatively. The physician then obtained a more detailed violence history. KC described how, during a recent family gathering, her partner became angry, punched her, knocked her down, jumped on top of her and began to strangle her, causing her to fear for her life. Although he was arrested, she continued to feel unsafe and experience insomnia. The physician evaluated her physical injuries, educated her about strangulation injury, conducted initial safety planning, documented his findings, and offered her referral to one of the clinic's health care advocates, a clinical psychologist, for further assistance. The physician introduced the psychologist to KC at the time of the initial medical encounter, and she agreed to an appointment. Initial assessment identified the following symptom picture: sleep onset and interruption insomnia, headaches, nightmares, unpredictable crying spells, worry, difficulty concentrating on work, intrusive thoughts, and decreased appetite. The agreed-upon treatment plan included relaxation to manage intense physical arousal, sleep hygiene strategies, return to previously enjoyable life experiences, supportive counseling, and referral to a legal advocate at the local women's center. During psychological intervention, KC frequently set up appointments with her family physician on the same day. With her consent, the physician and psychologist consulted

regularly about new developments, both positive and problematic, in her care. KC saw the psychologist for a total of 6 weekly sessions and one follow-up visit. During her last visit, she reported a nearly complete cessation of nightmares, insomnia, intrusive thoughts and headaches. Further, she returned to work and resumed her exercise program. She felt she had re-claimed her life and was prepared to proceed as a witness in criminal litigation in her partner's case. At her request, records of her medical and psychological treatment were provided to prosecution to aid in the litigation.

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## Inflammation and Traumatic Stress: A Likely Mechanism for Chronic Illness in Trauma Survivors

Kathleen Kendall-Tackett, PhD

Over the past decade, researchers in the field of psychoneuroimmunology (PNI) have made remarkable discoveries about the etiology of common chronic diseases, such as heart disease, diabetes, multiple sclerosis, and Alzheimer's. Each of these is due to increased levels of systemic inflammation (Kiecolt-Glaser et al., 2007; Pace et al., 2007; Robles et al., 2005). These findings have particular relevance to trauma survivors in that the human stress response activates inflammation. Sadly, trauma survivors have higher than average rates of many chronic diseases and often die prematurely, as the studies described below have found.



Kathleen Kendall-Tackett, PhD

An intriguing possibility is that some of this vulnerability to disease may be due to systemic inflammation.

### How Trauma Impacts Health

Using data from the National Comorbidity Study, researchers found that a history of childhood abuse increased the risk of cardiovascular disease. Interestingly, the link between child maltreatment and cardiovascular disease was especially strong for women, with maltreated women having a nine-fold increase in cardiovascular disease compared to non-maltreated women. The authors did not find a link between depression and cardiovascular disease; however, once child maltreatment was added to the analysis, the effect of depression disappeared. Indeed, it was trauma history, rather than depression, that accounted for the variance in cardiovascular disease (Batten et al., 2004).

Several other recent studies have found that health problems, disability, and suicidal behavior were more common in men and women with PTSD than their counterparts without PTSD. For example, analyzing data from the Canadian Community Health Survey ( $N = 36,984$ ), 1% ( $N = 478$ ) had a formal diagnosis of PTSD from a health care provider (Sareen et al., 2007). Even after adjusting for demographic factors and other mental illnesses, participants with PTSD had significantly higher levels of cardiovascular disease (hypertension and heart disease), respiratory

diseases (asthma and chronic obstructive pulmonary disease), chronic pain syndromes (fibromyalgia, arthritis, migraine), gastrointestinal illnesses (ulcerative colitis and ulcers), and cancer. PTSD was strongly associated with chronic fatigue syndrome and multiple-chemical sensitivity. There was no significant difference in rates of diabetes. PTSD was also associated with suicide attempts, poor quality of life, and short- and long-term disability. The authors concluded that these effects were above and beyond the effects of depression or other mental disorders and were the unique contribution of PTSD.

PTSD following a man-made disaster showed similar health effects (Dirkzwager et al., 2007). In this study, 896 survivors of a man-made disaster were surveyed at 3 weeks and 18 months after the disaster. These data were combined with health data one year before the disaster and four years after. (The disaster was an explosion of a fireworks depot that killed 23 people, injured 1,000, and forced the evacuation of 1,200 people). The authors found that PTSD was associated with physician-reported vascular, musculoskeletal, and dermatological problems. PTSD also increased risk of new vascular problems. These problems appeared even after controlling for previous health problem, smoking and demographic characteristics.

Not surprisingly, given the above-cited findings, people with PTSD use more health care services. In a study of women seeking health care at VA facilities ( $N = 2,578$ ), 33% ( $N = 858$ ) screened positive for PTSD (Dobie et al., 2006). The women with PTSD had more outpatient visits to the emergency department, primary care, medical or surgery subspecialties, ancillary services, and diagnostic tests. They had higher rates of hospitalizations and surgical procedures. The mean number of days in the hospital for a year was 43.4 for women with PTSD and 17 for women without PTSD. Women with PTSD were significantly younger than women without, were significantly less likely to be married, more likely to have a service-related disability, more likely to have chronic pain (e.g., irritable bowel syndrome and fibromyalgia), and more likely to be obese. They were also more likely to smoke, abuse alcohol and be depressed. Indeed, 75% of women with PTSD also screened positive for depression.

According to PNI research, many of these illnesses are due to trauma-related changes in the stress response. Severe or overwhelming stress alters and dysregulates the key systems that are designed to protect our lives. To understand these findings, it's helpful to review the three systems that respond to a perceived threat. These are described below.

### How Humans Respond to a Perceived Threat

Human bodies have a number of interdependent mechanisms in place designed to preserve our lives when we perceive danger. The human stress response is highly complex. But in a simplified form, it can be described as having three components: catecholamine, HPA Axis, and immune response.

The sympathetic nervous system responds first by releasing catecholamines (norepinephrine, epinephrine, and dopamine). This is the fight-or-flight response. The hypothalamic-pituitary-adrenal (HPA) axis responds with a

chemical cascade: the hypothalamus releases corticotrophin releasing hormone (CRH), which causes the pituitary to release adrenocorticotropin hormone (ACTH), which causes the adrenal cortex to release cortisol, a glucocorticoid.

A third part of the process is the immune response. One way the immune system responds to threat is by increasing inflammation through the production of proinflammatory cytokines. Cytokines are proteins that regulate immune response. Proinflammatory cytokines increase inflammation and serve the adaptive purpose of helping the body heal wounds and fight infection. A key finding of PNI research is that both physical and psychological stress can trigger the inflammatory response. In these studies, researchers generally measure three markers of inflammation in the plasma: proinflammatory cytokines, C-reactive protein, or fibrinogen.

The human stress response has a number of checks and balances built in to ensure that various components do not become overactive. Unfortunately, in the case of severe or chronic stress, the normal checks and balances fail. When they do, humans become vulnerable to disease. McEwen (2003) noted that physiologic mediators of the stress response (e.g., catecholamines, glucocorticoids, and cytokines) have an important role in allostasis—maintaining homeostasis through change. However, these mediators create wear on the system—or allostatic load—when they are “on” long-term or when overused during a challenge. Indeed, overuse can damage tissues and organs. It is this failure that leads to a series of physiologic consequences, such as sleep disruptions; changes to brain structures, such as the hippocampus and prefrontal cortex; bone mineral loss; abdominal obesity; and increased risk of cardiovascular disease.

### Inflammation in Trauma Survivors

There have been numerous studies during the past 10 years examining trauma's impact on two parts of the stress response: catecholamine and HPA axis. In both cases, researchers have found that trauma dysregulates these physiologic processes. Only recently have researchers examined the impact of trauma on the inflammatory response. Although a relatively new area of study, several researchers have found that traumatic events increase levels of proinflammatory cytokines in trauma survivors. The increase in inflammation likely mediates the relationship between trauma and health problems.

Childhood maltreatment was shown to affect clinically relevant levels of C-reactive protein when measured 20 years later in abuse survivors (Danese et al., 2007). The participants ( $N = 1,037$ ) were part of the Dunedin Multidisciplinary Health and Development Study, a study of health behavior in a complete birth cohort in Dunedin, New Zealand. Participants were assessed every two to three years throughout childhood, and every five to six years through age 32. The effect of child maltreatment on inflammation was independent of co-occurring life stresses in adulthood, early life risks, or adult health or health behavior. Along these same lines, white blood cell count and fibrinogen were also elevated in those

*continued on p. 14*

## Inflammation and Traumatic Stress

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who experienced childhood physical or sexual abuse. Severity of abuse was related, in a dose-response way, to severity of inflammation.

In a study of intimate partner violence (IPV), 62 women who had been in abusive relationships were compared with women who had not (Woods et al., 2005). The researchers found that interferon- $\gamma$  (IFN- $\gamma$ ) levels, another inflammation marker, were significantly higher in abused versus non-abused women, and in women with current PTSD symptoms versus women without PTSD. Fifty-two percent of women in the IPV-group reported depression, and 39% had high levels of PTSD symptoms. The level of IFN- $\gamma$  was mediated by PTSD symptoms in this sample, and was not related to other potential confounding variables. These findings also demonstrated the lingering health effects of intimate partner violence in women who experienced violence 8 to 11 years previously, yet were still manifesting significant physical symptomatology.

Immune parameters were also altered in a study of rape (Groër et al., 2006). In this study, 15 women who had been raped were compared with 16 women who had not been sexually assaulted on levels of immune markers. Women who had been raped were assessed 24 to 72 hours after their assault. The findings revealed that women who had been sexually assaulted had higher cytotoxic cells and proinflammatory biomarkers than the control group. Specifically, the sexually assaulted women had higher ACTH, C-reactive protein, IL-6, IL-10, IFN- $\gamma$  than women in the control group. In addition, the assaulted women had lower B lymphocyte counts and decreased lymphocyte proliferation. The researchers interpreted their findings as indicating that sexual assault activated innate immunity and suppressed some aspects of adaptive immunity. If these long-term alterations persist, they could lead to health problems in rape survivors.

In a sample of 14 otherwise healthy patients with PTSD and a matched group on age and gender of 14 patients without PTSD, von Kanel and colleagues (2006) investigated blood coagulation. They noted that PTSD increases risk of cardiovascular disease and that the mechanism for this relationship is not well understood. In this study, they investigated whether PTSD was associated with coagulation activity by measuring various clotting factors (FVII:C, FVIII:C, FXII:C), fibrinogen, and D-dimer in the plasma. They found that FVIII:C was predicted by hyperarousal severity and overall PTSD severity. In patients with PTSD, hyperarousal and overall PTSD severity predicted fibrinogen. The more severe the PTSD, the greater the concentration of these coagulation factors. They concluded that PTSD may elicit hypercoagulability, even at subthreshold levels, and this may increase risk for cardiovascular disease in trauma survivors.

## Summary

Trauma has a demonstrated negative impact on health. PNI research indicates that one possible mechanism by which trauma increases risk of illness is its effects on systemic inflammation. Fortunately, inflammation can be specifically and easily addressed in health care settings, and a wide range of treatments specifically lower inflammation. With information from these studies, practitioners can address both the mental and physical health issues of trauma survivors—increasing their health and longevity in the process.

*Kathleen Kendall-Tackett, PhD, is a Research Associate at the Family Research Laboratory, University of New Hampshire, and Division 56 Secretary. This article is excerpted from Kendall-Tackett, K. A. (Ed.). (in press). The psychoneuroimmunology of chronic disease. American Psychological Association.*

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# A Developmental Perspective on Trauma Training

*Carole L. Campbell*  
*Children's Hospital of The King's Daughters and*  
*Eastern Virginia Medical School*

*Elissa J. Brown*  
*St. John's University*

*Madeline Amato*  
*St. John's University and North Shore University/*  
*Long Island Jewish Health System*

*Komal Sharma*  
*St. John's University*

Expertise in the trauma field has grown exponentially in the past 20 years. National organizations, such as the American Psychological Association, have provided training guidelines related to trauma (APA, 1995), listings of trauma training programs (Division 56), and international trauma training guidelines (Weine et al., 2002). This growth has impacted not only the field itself, but the opportunity for trauma training with both generalists and the next generation of trauma experts.

Despite the expansion of information and expertise in the trauma field, there is a gap in incorporating this information into training. As trauma specialists at various stages in our careers, we have had a range of experiences with training in the field. In this article, we first discuss the status of training opportunities at different developmental levels, turn to their strengths and limitations, and, finally, discuss recommendations to trauma professionals for advancing trauma psychology education.

## Training in Trauma

### *Undergraduate opportunities*

There has been a steady increase over time in the number of degrees conferred in psychology. More than 82,000 students received Bachelor's degrees in psychology in 2004 (National Science Foundation, 2006). Two reviews of undergraduate psychology curricula suggested that a majority of programs offer a general degree with some advanced and integrative (capstone) courses concluding the training (Messer, Griggs, and Jackson, 1999; Perlman and McCann, 1999). Despite a variety of concentrations and specializations listed (e.g., clinical, graduate preparation, developmental, physiological), neither review identified trauma psychology as a specialization area for undergraduate trainees. Either the programs are unavailable or they are available, but poorly publicized. Thus, for undergraduates interested in specializing in trauma, the majority of opportunities lie outside of the classroom, such as through volunteering with faculty specializing in trauma, or at an agency that serves trauma survivors, such as a rape crisis center.

### *Graduate opportunities*

Graduate trainees vary widely in their interest in and experience working with traumatized clients. Given that over half of the United States population will experience a traumatic event in their lifetime (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), it is likely that graduates will work with at least one traumatized client. However, among those that are not specializing in trauma (a majority of graduate students), a majority of students receive only cursory trauma training. Most are exposed to mandatory child abuse reporting seminars and trauma may be mentioned in the context of risk factors for the development of psychopathology (e.g., posttraumatic stress disorder; PTSD).

For those students seeking additional trauma training beyond the standard curricula, opportunities exist through specialized clinical experiences (e.g., trauma practicum), as research assistants on trauma research programs, or by obtaining membership in some trauma-related organizations (e.g., Trauma Psychology division of APA, the International Society for Traumatic Stress Studies [ISTSS], and the American Professional Society on the Abuse of Children [APSAC]). Websites such as that of the National Child Traumatic Stress Network (NCTSN; [www.nctsn.org](http://www.nctsn.org)) and trauma-focused cognitive behavioral therapy (TF-CBT; <http://tfcbt.musc.edu/>), as well as trauma-specific (e.g., ISTSS) and generalist organizations (e.g., APA) also offer opportunities to gather information about and gain training in trauma.

### *Post-graduate opportunities*

A variety of post-graduate training opportunities provide depth in trauma training. Clinically and research-oriented postdoctoral fellowships offer specialized training in trauma, with many funded by the National Institutes of Health and other federal agencies (e.g., Boston University, University of Pittsburgh, St. John's University, Medical University of South Carolina). The National Data Archive on Child Abuse and Neglect (NDACAN) offers a summer research institute geared at providing specialized training and networking opportunities in research on child abuse and neglect. Finally, multiple workshops and symposia are offered through trauma-related organizations, such as ISTSS, APSAC, as well as through more generalized organizations, such as the Association for Behavioral and Cognitive Therapies (ABCT). An abundance of journals and newsletters, such as this one, serve as resources for learning about trauma.

## Pros and Cons of Trauma Training Opportunities

### *Undergraduate training*

For undergraduate students, the focus on breadth of knowledge might limit the opportunity for those interested in pursuing specialization in trauma. Thus, many students are not aware of a trauma subspecialty or of the resources and organizations that might offer opportunities for trauma training. Although students may be exposed to trauma

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## A Developmental Perspective...

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specialization through a mentor who has a similar interest, such mentorship can be limited by the expertise of the faculty of the particular university. Thus, the effort and time needed for students to receive this training is often on the student. Further, those undergraduates knowledgeable about and interested in trauma often are not exposed to issues of maltreatment, violence, or other forms of trauma exposure in undergraduate courses.

### Graduate training

Graduate psychology education offers considerably more opportunities for trauma training, including opportunities to specialize. The APPIC directory lists over 250 predoctoral internship sites identifying “Trauma” as a major focus. Nonetheless, as Bronson-Castain (2008) reported, 28% of directors of internship sites with a major trauma rotation said that interns were “Not Prepared” to work with a trauma population. It is apparent that trauma training for graduate students is limited in a number of ways. Child physical and sexual abuse tends to be highlighted to a greater extent than other forms of trauma (e.g., domestic violence, exposure to community violence, medical trauma). Even when written standards exist (e.g., state guidelines for child abuse reporting), they may be implemented differently by graduate program, internship site, training facility or clinician, leading to confusion among trainees. Finally, as with undergraduates, the impetus is on students to seek out relevant training experiences. Graduate students may not know of trauma as an area of specialization. Those interested in trauma may be limited by confusion about where to access relevant information and training opportunities, concern that trauma is a difficult field to “break in to” and costs associated with gaining training outside of their general program.

### Postdoctoral training

The breadth and depth of postdoctoral trauma training opportunities are certain strengths for those interested in specializing in this area beyond graduate education. Further, these opportunities are critical for furthering the field of trauma research and practice and allow for recognition of this vast public health problem that affects a majority of the population. Despite their societal value, there is a price on offering these training opportunities, and most of them are costly. In addition, the specificity inherent in these opportunities does not lend well to disseminating information on evidence-based trauma practices more broadly to trainees. Finally, there lacks an active forum for collaboration and dialogue about trauma at the postdoctoral level, which can be isolating for trainees.

### Recommendations

As educators, clinicians, and advocates dedicated to trauma psychology, we have the opportunity to improve trauma training in multiple ways. First, there needs to be a stronger effort to incorporate trauma knowledge into undergraduate curricula, an effort that will likely have an added benefit of recruiting stellar undergraduates to the

field of trauma. Trauma knowledge and research is relevant to many areas of psychology and could be included in developmental, abnormal, and other core courses. More broadly, knowing behavioral correlates of trauma might be helpful for those going into many fields (e.g., education, medicine, law). Professional organizations might serve as venues for discussion of curricula and experiential learning methods for incorporating trauma education across undergraduate and graduate courses.

Professionals who work in trauma-focused sites should forge connections with community agencies and school training programs, meeting the dual purpose of providing valuable training experiences for students and needed services to traumatized populations. Including undergraduate volunteers with graduates might offer vertical training and an opportunity to learn of the emotional toll of work and time commitment that often accompanies trauma work. Additionally, the typical model of one trainee-one supervisor might be rethought when students are exposed to multiple trauma cases. In our experience, creating a collaborative supportive working environment is optimal and allows students a place to discuss clinical and emotional concerns. Moreover, trainees are exposed to a range of professional opinions and refine their own ideas, rather than internalizing the standards of one supervisor. Graduate trainees should be educated about agencies involved with traumatized populations. Finally, professionals working with graduate trainees in a trauma-related site should keep in mind the importance of discussing the limitations of their services (e.g., knowing when to seek outside consultation or refer clients to other facilities).

Consistent with ISTSS and APA guidelines, incorporating trauma among training in other specialties might be of particular benefit. For example, trauma experts might collaborate with experts in other fields (such as depression and anxiety) to do didactics in trauma assessment, PTSD, comorbidity, and treatment for generalist trainees. Trauma-related organizations might form postdoctoral groups where trainees at this level can discuss training experiences as well as professional development activities.

Institutional support of the trauma field, in the form of funding for specialized clinical and research fellowships, scholarships for advanced training institutes, and inclusion of trauma education in generalized venues, is essential for defraying the cost of specialized training. Only with such support from individual faculty members, department leaders, organizations, and governmental entities, can quality trauma training be maintained and advanced.

### Professional Applications

Traumatized youth are served by multiple professional disciplines (e.g., psychologists, clergy, emergency room physicians, teachers, social workers, psychiatrists, hotline workers), all of which have their own guidelines and philosophies. Additionally, generalists and lay people often express knowledge about trauma (e.g., water-cooler comments about causes and consequences). Numerous questions about what defines a “trauma expert,” worthy of training others, need to be addressed. Who should have the



authority to decide? Based on what (e.g., education versus experience versus peer recommendations)? Is there even a need for formal standards (analogous to ABPP)?

The lack of certification as a trauma expert may result in problems among colleagues, including the training of students. Some trauma psychologists work within specialized trauma programs, but most trauma specialists work among psychologists with various specialties, all of whom have some knowledge of trauma. As a result, the trauma specialist may not be consulted on clinical, research, and program development issues of relevance. In addition, there may be a lack of sensitivity to the need to provide trauma-specific training to students. Training students in trauma involves informing them of epidemiology, etiology, methods of assessing trauma and trauma-related responses, and interventions (both prevention and treatment). Presentation of this material is done through multiple lenses; trauma psychologists are teachers, researchers, clinicians, public policy informants, and advocates.

There is a distinct parallel process in which trauma-informed, evidence-based techniques are helpful in teaching and mentoring students. For example, considering context and prior history, using a psychoeducational framework, and practicing skills prior to use are techniques that I use with students, and encourage students to use with trauma survivors. The work environment is one that promotes safety, social support, and open communication without secrets. As mentors, we need to prevent vicarious traumatization and teach students how to care for themselves as they develop professionally. Because students (and mentors) may be interested in trauma work as a result of their own trauma histories, the role of self-disclosure must be discussed. A topic worthy of study is the value of mentor self-disclosure to trainees.

As trauma psychologists, we are interested in growing the field with competent, dedicated junior colleagues. The challenge is identifying those students. Empirical research is unavailable, so based solely on the authors' experiences, we have hypothesized characteristics of stellar trainees. Beyond the personality traits that appear to characterize successful undergraduate and graduate students, future trauma psychologists may benefit from being comfortable advocating for others and managing complicated systems, having strong coping mechanisms including a (dark) sense of humor, having an ability to balance between empathy, humility, and inner strength, and loving chocolate (this may really be about sharing and self-care).

Additional values of a successful trauma team are modeled by the firefighter community, with whom we had the honor of working after the World Trade Center attacks on September 11<sup>th</sup>. Firefighters are about the team; there are no heroes. If one person acts alone as a hero, someone dies. Working together makes us successful. This team mentality is applied not only to their work, but to their personal lives. If someone is moving, everyone in the house packs and unpacks. Social support and connectedness are critical. The firefighters each have a role during a fire, but also act as back-up of one another. In a successful trauma team, trauma survivors depend on junior staff who, in turn, lean on senior staff who, in turn, have colleagues in other settings who

provide peer supervision. The last domino cannot fall.

In addition to peer supervision and support, trauma specialists need ongoing training in content and methods relevant to trauma survivors. Content areas may include what to teach (i.e., updates on evidence-based practice) and how to teach (i.e., updates on pedagogic advances). Formal training methods include attending conferences, and participating in list serves, specialized working groups (e.g., Trauma and Stress Special Interest Group of ABCT), and national networks (e.g., NCTSN). Informal training may involve participating in supervision, discussion with other trauma specialists, and soliciting feedback from trauma survivors. This training provides a setting in which psychologists and psychology students both glean and share knowledge.

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## Fall 2008 Issue



Topher Collier, PsyD

The *Trauma Psychology Newsletter* is accepting articles for the Fall 2008 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 **September 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](mailto:DrTopherCollier@aol.com).

In the winter edition of *Trauma Psychology*, the student section published an article which examined whether internship site training directors felt their interns were adequately prepared for internships working with trauma populations. The findings revealed that many training directors believed that students could better prepare themselves for trauma-related internships if they took more trauma-related classes, gained trauma experience in their practica, and became more familiar with the literature on trauma treatment. Subsequently, we decided to do a follow-up article which explored how prepared and supported interns felt about their training programs in regards to trauma. A survey was sent out on-line to current interns to get the student perspective. Ashley Dillon, MA, a first-year student from Pacific Graduate School of Psychology in Palo Alto, California discusses the results from this survey and her personal interview with a current trauma intern in the article below.

## Intern Responses to Readiness for Trauma-Related Pre-doctoral Internship

Ashley Dillon, MA  
Pacific Graduate School of Psychology

According to the winter article *Preparing Interns for Trauma Focused Internships* by Gabriela Bronson-Castain, 28% of internship site training directors who participated in the survey felt that their interns were not adequately prepared for internships in trauma. This led me to the question: If these interns were not prepared for the basic tenets of trauma treatment, how would they experience a complicated process like vicarious trauma? Vicarious trauma is a stress reaction that therapists and other service professionals often experience when their patients share their traumas. Vicarious trauma may occur without the therapist realizing that it is happening to them and can have a tremendous emotional impact on the therapist.

I had the opportunity to conduct a personal interview with a current trauma intern, Allison B. in which we discussed her understanding and experience of vicarious trauma. Allison is currently completing her internship at a large, urban outpatient clinic working with severely abused and neglected children. Her patient population has included survivors of sexual, physical, and community violence. She sees patients in individual therapy, as well as regularly administers full psychological batteries. I asked Allison how much she was aware of vicarious trauma before she started her internship. Allison responded that she first learned about vicarious trauma from a theoretical standpoint in her class work. However, it wasn't until she began seeing patients who had experienced high levels of trauma that she began to understand the possible impact of vicarious or secondary trauma. Fortunately, her placement addressed these issues in trainings. However, when Allison started her internship, no one discussed vicarious trauma, so when she began to have overwhelming feelings of anxiety and fear, she didn't fully understand what was happening. She used her school-based knowledge and previous experience to help her identify what she was feeling, but it didn't help her process the vicarious trauma. Allison stated, "vicarious trauma can start out so subtly that it can come into your life without you realizing it." I asked her how

interns could work through the impact of vicarious trauma and she stated: "Have it be a known entity and talk about it within the agency. Have the agency staff acknowledge that it exists and how important it is [to discuss] when working with this population, diversify your caseload so you are not overwhelmed by trauma, consult with peers, attend personal therapy sessions, and take self-care within one's life." Allison

reported that even if you know about vicarious trauma intellectually, you will not necessarily be prepared for it in a clinical setting. Finally, when we discussed if academic programs should incorporate vicarious trauma into the coursework, Allison's response was, "No, incorporating [the impacts of vicarious trauma] is the ongoing work of an agency. One cannot cognitively prepare for [vicarious trauma] because it's an emotional experience. It should be addressed while it is happening. Some education is needed before but it should be an ongoing process." For Allison, her training year has been a positive experience because she got support

from her intern group and in her individual therapy, but she felt that her agency missed an opportunity to teach and support the current interns, who are the next generation of future psychologists working with trauma.

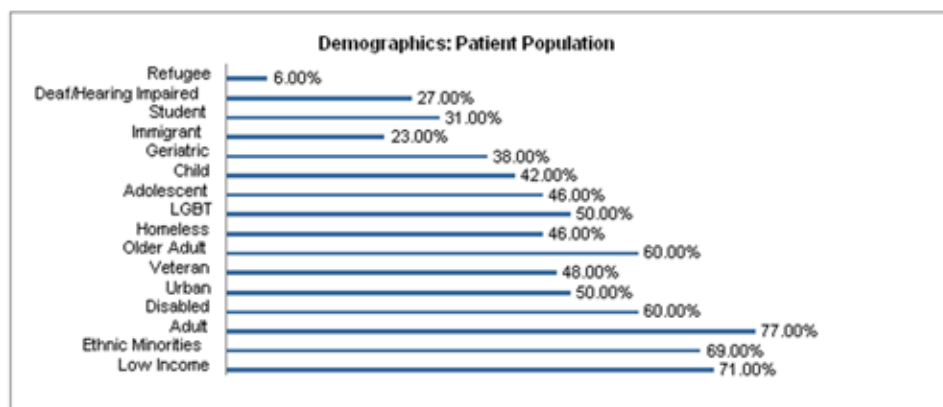
Allison was one of the many students who participated in the online survey that was sent out to current interns to determine their level of readiness for trauma-related pre-doctoral internships. A survey was emailed to 266 training directors in the APPIC directory who identified "trauma" as a major focus of their training program. These training directors were asked to forward the survey on to their interns. It is unclear how many students in trauma internships actually received the email. But of the 266 training directors who were sent the survey and forwarded the email to their interns, 50 responded to the query. Responses came from a wide range of internship sites serving adults, children, adolescents, ethnic minorities, veterans, geriatrics, LGBT, deaf/hearing impaired, disabled, students, immigrants, refugees, urban, low-income, and homeless populations. (See Figure 1).

The survey consisted of open-ended questions focusing on three components: how academically prepared interns felt they were to work with trauma populations, how training directors and schools can better prepare students for this population, and what treatment modalities are used



Ashley Dillon, MA

Figure 1



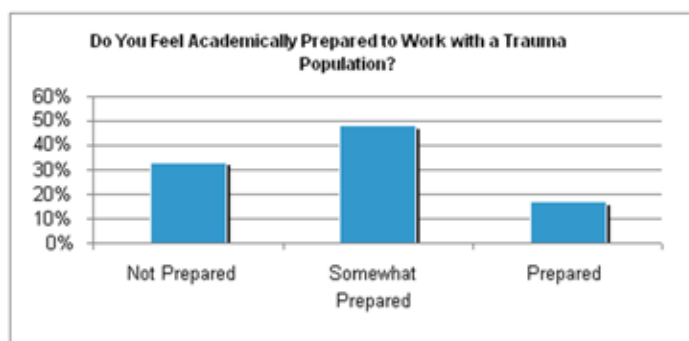
at internship sites. Interns were asked to respond to the following questions:

1. How well do you feel that your education prepared you to work with a trauma population?
2. Did you take a trauma-related class(es)? If so, which ones?
3. What classes would you recommend your school offer in order to better prepare students for trauma-related internships?
4. In what other ways can your school help students to be more prepared for working with trauma populations?
5. Do you feel that your internship is adequately preparing you for working with a trauma population?
6. What trauma treatment(s) does your training program use?
7. How has your program addressed issues of vicarious trauma?
8. What advice would you give to training programs to help future trainees prepare for internships?

### Readiness Level for Trauma Work

There were mixed responses on whether interns felt academically prepared in working with trauma populations. Of those who responded to the question: 33% of the interns believed that their education prepared them very little for working with trauma populations; 48% stated that their education prepared them moderately for working with trauma populations; and 17% mentioned that they felt extremely or very well prepared for working with trauma populations. 17% of the interns mentioned that they felt extremely or very well prepared for working with trauma populations (See Figure 2). One student commented by

Figure 2



saying, “Extremely well. My research group focused on trauma and my graduate school had many trauma-focused clinicians on staff, resulting in a variety of opportunities.” The previous survey results by Bronson-Castain showed that fewer training directors felt that interns were unprepared (28%) compared to the reports from interns reported in this article (33%). The previous survey results also showed that more training directors felt their interns were very prepared (35%), compared to the results presented in this article (17%).

### Academic Preparedness

A vast majority (73%) of interns stated that they did not take any courses related to trauma. However, trauma-related issues were often integrated in other courses. When asked which classes the interns would recommend to their schools in order to better prepare students for working with trauma populations, interns responses varied. One intern wrote “Trauma theory, CBT focused trauma theory, Trauma and attachment.” Another intern wrote, “Empirically supported treatments for types of trauma.” From the responses received, course recommendations seemed related to the subpopulation that the respondent was interested in working with. In the previous survey, training directors also wanted more classes on trauma theory and empirically supported trauma treatment, but stated further that they wanted schools to provide more classes on the treatment of PTSD, complex PTSD, the neurobiology of trauma, dissociation and psychosis, and trauma assessment measures.

Interns were then asked how schools could help students to be more prepared for working with trauma populations. Interns stated that their schools could prepare students by offering more trauma-related seminars and clinical workshops, and by discussing trauma-related case material in classes. Interns also mentioned that they would like their schools to reach out to the community and provide more clinical opportunities with trauma populations, including work with domestic violence shelters, the American Red Cross, FEMA, and police departments.

### Internship Preparedness

When interns were asked whether their internships had adequately prepared them for working with trauma populations: 73% of the interns said “yes”; 14% of the interns said “no”; and 11% said that they felt “somewhat” prepared. When asked which models of trauma treatment are used within their internship program, 81% identified specific treatment modalities such as Cognitive Behavioral Therapy (CBT); Dialectical Behavioral Therapy (DBT); Cognitive Processing Therapy (CPT); and Prolonged Exposure Therapy (PE).

Lastly, interns were also asked if their programs had addressed issues of vicarious trauma and 38% said that their programs had not included it in their training thus far. Surprisingly, only 11% of the interns stated that their

## Intern Responses to Readiness...

*continued from p. 19*

programs have taught about the impact of vicarious trauma. Interns were given the opportunity to provide advice to training programs to help future trainees prepare for internships. Several interns said that they would recommend providing “More didactic and reading material up front.”

Across the two surveys, there were more commonalities in the responses than differences. Both groups encouraged schools to offer more trauma-related classes. Training directors had a clear idea of areas in which they wanted their interns to improve their knowledge about trauma. Over two-thirds of the interns were satisfied with

the level of trauma training they received at their internship site. But an area of attention that may be missing in both academic and internship settings is preparing interns for the impact of vicarious trauma and helping them work through it as it occurs.

*I would like to thank all respondents to this survey. Student affiliates that are interested in writing an upcoming article for the student section of this newsletter should email us at gbcastain@jfkku.edu. If you are not currently a student member of Division 56, you can join today and the \$10 annual membership fee will be waived for the first year. If you have any questions about student membership or joining the student committee, feel free to email us at apadivision56jill@gmail.com.*

## Division of Trauma Psychology Convention Program Preview

### Workshop

#### **Sexually Reactive Behavior in Young Children—Theory Informing Treatment**

Thursday, August 14, 2008, 8:00 AM–8:50 AM

Boston Convention and Exhibition Center Meeting Room 157B

DeDe Wohlfarth, PsyD, Chair; Kristin Shaner-Rose, MEd; Sarah Janes, MA; Renee Flaherty, MEd; Michelle Matzke, BA; Taryn Bellgard, BA; David Wen, BA  
Spalding University, Louisville, KY

### Paper Session

#### **Trauma in Diverse Populations**

Thursday, August 14, 2008, 9:00 AM–9:50 AM

Boston Convention and Exhibition Center Meeting Room 156C

Minal Bopaiah, MA  
Fordham University, Bronx, NY  
*Reactions to Torture: Comparing Punjabi and Tibetan Survivors*

Thema Bryant-Davis, PhD  
Pepperdine University, Encino, CA  
*Poverty, Educational Attainment, and Partner Abuse of African American Mothers*

Christopher M. Weaver, PhD  
VA Palo Alto Health Care System, Menlo Park, CA  
*Criminal Offending History in Male Veterans With SUD and PTSD*

### Symposium

#### **Project Fleur-de-lis—Collaborative Behavioral Therapy Efforts Addressing Trauma in Children**

Thursday, August 14, 2008, 10:00 AM–11:50 AM

Boston Convention and Exhibition Center Meeting Room 157C

Baraka W. Perez, PhD, Chair  
Mercy Family Center, Metairie, LA

Jennifer V. DuClos, MA  
Mercy Family Center, Metairie, LA  
*Project Fleur-de-lis: A Three-Tiered Model of Care*

Kathleen Whalen, LCSW, MEd  
Save the Children, New Orleans, LA  
*CBI: Building Resiliency as Part of Recovery*

Douglas W. Walker, PhD  
Mercy Family Center, Mandeville, LA  
*Cognitive Behavioral Intervention for Trauma in Schools: Trauma and Natural Disasters*

Judith A. Cohen, MD, Discussant  
Allegheny General Hospital, Pittsburgh, PA  
*Trauma-Focused CBT for Children and Parents Experiencing Disasters*

### Symposium

#### **Aftermath of the Virginia Tech Shootings—Distress and Resilience**

Thursday, August 14, 2008, 12:00 PM–1:50 PM

Boston Convention and Exhibition Center Meeting Room 211

Heather Littleton, PhD, Chair  
Sam Houston State University, Huntsville, TX

Danny Axsom, PhD  
Virginia Tech University, Blacksburg, VA  
*Help Giving Following the Virginia Tech Shootings*

Amie E. Grills-Taquechel, PhD  
University of Houston, Houston, TX  
*Predictors of Anxiety and Quality of Life After Mass Trauma*

Heather Littleton, PhD  
Sam Houston State University, Huntsville, TX  
*Predicting Trauma Symptoms Following the Mass Shooting: Risk and Resilience*

Dean G. Kilpatrick, PhD, Discussant  
Medical University of South Carolina, Charleston, SC

## Symposium

### Trauma and Refugees—Recent Advances in Science and Practice

Thursday, August 14, 2008, 2:00 PM–3:50 PM  
Boston Convention and Exhibition Center Meeting Room 208

Meredith Charney, PhD, Chair  
Boston University, Boston, MA

Meredith Charney, PhD  
Boston University, Boston, MA  
*Understanding the Psychological, Psychosocial, and Physical Health Status of HIV-Positive Refugees*

Linda Piwowarczyk, MD, MPH  
Boston Medical Center, Boston, MA  
*Development of an Instrument Evaluating the Impact of Torture on Functioning*

B. Heidi Ellis, PhD  
Children's Hospital Boston/Harvard Medical School, Boston, MA  
*Adapting Interventions for Refugee Youth: Trauma Systems Therapy for Somali Adolescents*

Theresa Stichick Betancourt, DSc, MA  
Harvard University, Boston, MA  
*Mental Health Interventions for War-Affected Youth: Examining Differential Effects of Group Interpersonal Therapy Intervention by Gender and History of Abduction*

Terence M. Keane, PhD, Discussant  
VA Boston Healthcare System, Boston, MA



## Discussion

### Recruitment and Retention in Trauma Research—Meeting the Challenge of Special Populations

Friday, August 15, 2008, 8:00 AM–8:50 AM  
Boston Convention and Exhibition Center Meeting Room 160C

David L. Meyer, PhD, Chair  
VA Boston Healthcare System, Boston, MA

Suzy B. Gulliver, PhD  
VISN 17 Center of Excellence for Research on Returning War Veterans, Waco, TX  
*Trauma Research in Firefighters: Challenges of Recruitment and Retention*

Jennifer J. Vasterling, PhD  
VA Boston Healthcare System, Boston, MA  
*Longitudinal Retention in a Military Sample: Neurocognition Deployment Health Study*

B. Heidi Ellis, PhD  
Children's Hospital Boston/Harvard Medical School, Boston, MA  
*Trauma Research With Refugees: Community-Based Participatory Research Methodology*

## Paper Session

### Neurocognitive Functioning in Traumatized Populations

Friday, August 15, 2008, 9:00 AM–9:50 AM  
Boston Convention and Exhibition Center Meeting Room 157A

Ibrahim A. Kira, PhD  
ACCESS Community Health and Research Center, Dearborn, MI  
*Relationship Among Mental Health, Trauma, Dose, Types and Profiles, and IQ: The Case of African American and Iraqi Refugees*

Carryl P. Navalta, PhD  
McLean Hospital/Harvard Medical School, Belmont, MA  
*Neurocognitive Functioning in Young Adults Exposed to Childhood Interparental Violence*

Rafael Art Javier, PhD  
St. John's University, Jamaica, NY  
*Exposure to Violence and Cognitive Functioning in Ethnic Minorities*

## Poster Session

### Trauma-Related Assessment and Treatment

Friday, August 15, 2008, 2:00PM–2:50PM  
Boston Convention and Exhibition Center Exhibit Halls A and B1

Ruth Elaine Graves, PhD, Howard University, Washington, DC  
*Recognizing and Treating PTSD in the Primary Care Setting*

Susanne Lee, MPH, Stanford University, Palo Alto, CA  
*Feasibility and Acceptability: Computerized Assessments for Trauma and HIV Populations*

*continued on p. 22*

## Convention Program Preview

*continued from p. 21*

Sarah F. Lewis, PhD, Center for Research, Assessment, and Treatment Efficacy, Asheville, NC

*Posttraumatic Stress and Treatment Outcomes: A Test of Mediating Variables*

Terri L. White, PhD, University of Louisville, Louisville, KY

*Secondary Traumatic Stress and Burnout in the Helping Professions*

Troy W. Ertelt, BA, University of North Dakota, Grand Forks, ND

*Evaluations of Victims of Child Sexual Abuse: A Systematic Approach*

Kathleen A. Moore, PhD, University of South Florida, Tampa, FL

*Trauma-Informed Care for Substance-Abusing Women in Child Welfare*

Thomas A. Campbell, MS, Virginia Commonwealth University, Richmond, VA

*Survey of Therapist Methods in the Treatment of Torture Survivors*

Pei-Yi Lin, MEd, University of Kentucky, Lexington, KY

*Trauma Counselors' Voices: Professional Support in Counseling Sexual Abuse Survivors*

Nicholas A. Mescia, MA, University of Miami, Miami, FL

*Women, Trauma, and Psychological Distress: Implications for Improving Treatment Effectiveness*

Hiroko Mori, PhD, Bunkyo University, Koshigaya, Saitama Prefecture, Japan

*Secondary Trauma in Japanese Counselors Working With Domestic Violence Survivors*

Michael P. Mann, PhD, Mississippi College, Jackson, MS

*Youth Suicide Prevention and Intervention Project*

Rachel L. Wiedeman, BA, University of Tulsa, Tulsa, OK

*Why Training Matters: Motivation, Preparedness, and Readiness of Disaster Responders*

Jacob A. Bentley, MA, Seattle Pacific University, Seattle, WA

*Mental Health Perspectives Among Cambodian and Somali Refugee Populations*

Joleen C. Schoulte, BS, University of Iowa, Iowa City, IA

*Do Grief Measures Really Measure Grief?*

Alicia N. Copping, BA, University of Tasmania, Launceston, Tasmania, Australia

*Negotiating the Postlife-Crisis Journey: An Australian Model*

Alicia N. Copping, BA, University of Tasmania, Launceston, Tasmania, Australia

*Cross-Cultural Differences in Positive Post Life-Crisis Adaptation*

Angeleque Akin-Little, PhD, Behavioral, Educational, and Research Consultants, Tupelo, MS

*Stories of Katrina and Rita: Children's Perspectives*

Melissa J.S. Carmel, BA, State University of New York at Albany, Albany, NY

*Relation of Secondary Traumatization to Perceptions of Therapeutic Alliance*

Hae-Soo Kweon, PhD, Korea Youth Counseling Institute, Seoul, South Korea

*Exploration of Healing Process of Korean Female Sexual Abuse Survivors*

Tricia L. Orzeck, PhD, MA, University of Calgary, AB, Canada

*Relationship Trauma: A Grounded-Theory Investigation*

Karen G. Langer, PhD, Independent Practice, New York, NY

*Psychological and Posttraumatic Stressors of Identity Theft*

Naji Abi-Hashem, PhD, Independent Scholar, Seattle, WA and Beirut, Lebanon

*Understanding the Coping Styles of Arab-Middle Eastern Immigrants and Refugees*



## Symposium

### Conceptions and Misconceptions of Posttraumatic Growth

Friday, August 15, 2008, 3:00PM–3:50PM

Boston Convention and Exhibition Center Meeting Room 259B

Lawrence G. Calhoun, Jr., PhD, Chair

University of North Carolina at Charlotte, Charlotte NC

Richard G. Tedeschi, PhD,

University of North Carolina at Charlotte, Charlotte NC

*Models of Posttraumatic Growth: Recent Developments and Misconceptions*

Jane Shakespeare-Finch, PhD

Queensland University of Technology, Carseldine, Queensland, Australia

*Cultural Similarities and Differences in Conceptions of Posttraumatic Growth*

Alan F. Friedman, PhD  
Northwestern University Medical School, Chicago, IL  
*Posttraumatic Growth in the Courtroom and the Media*

Lisa D. Butler, PhD, Discussant  
Stanford University School of Medicine, Palo Alto, CA

## Symposium

### Trauma and HIV/AIDS—Implications for Clinical Care, Prevention, and Research

Friday, August 15, 2008, 4:00PM–4:50PM  
Boston Convention and Exhibition Center Meeting Room 152

Cheryl Gore-Felton, PhD, Chair  
Stanford University, Palo Alto, CA

Stephen M. Brady, PhD  
Boston University School of Medicine, Boston, MA  
*Gay Men and Trauma: Implications for Intervention and Prevention*

Cheryl Gore-Felton, PhD,  
Stanford University, Palo Alto, CA  
*Dissociation, PTSD, and Childhood Abuse Among HIV-Positive Adults*

Mark Vosvick, PhD  
University of North Texas, Denton, TX  
*Trauma, Stigma, Forgiveness, and Quality of Life in HIV-Positive Adults*

## Symposium

### Effectively Blending Play-Based Techniques With CBT Child Sexual Abuse Treatment

Friday, August 15, 2008, 5:00PM–5:50PM  
Boston Convention and Exhibition Center Meeting Room 213

Athena A. Drewes, PsyD, MA, Chair  
Astor Home for Children, Poughkeepsie, NY

Anne L. Stewart, PhD  
James Madison University, Harrisonburg, VA  
*Therapeutic Value and Power of Play With Children*

Athena A. Drewes, PsyD, MA  
Astor Home for Children, Poughkeepsie, NY  
*Integrating Play-Based Interventions With Cognitive--Behavioral Therapy and Evidence-Based Treatments*

Lauren Hallion, BA,  
Astor Home for Children, Rhinebeck, NY  
*Recent Research Outcome Studies and Play-Based Approaches*

## Social Hour and Dessert Reception

Friday, August 15, 2008, 8:00PM–9:50PM  
Boston Marriott Copley Place Hotel Salons A, B, and C

## Symposium

### Dissociating Dissociation—Views From the Trauma Psychology Dissociation SIG

Saturday, August 16, 2008 8:00AM–8:50AM  
Boston Convention and Exhibition Center Meeting Room 252B

Harold D. Siegel, PhD, Chair  
Independent Practice, Westbury, NY

Lisa D. Butler, PhD  
Stanford University School of Medicine, Palo Alto, CA  
*Dissociative Experiences in Everyday Life*

Annita B. Jones, PsyD  
Independent Practice, Allentown, PA  
*Ruling “In” Dissociation: A Mental Status Evaluation Guide for Clinicians*

Elizabeth F. Howell, PhD  
Independent Practice, New York, NY  
*Trauma and Dissociation*

## Discussion

### Ending Long-Term Trauma Psychotherapies—Clinical and Ethical Considerations

Saturday, August 16, 2008, 9:00AM–10:50AM  
Boston Convention and Exhibition Center Meeting Room 257B

Karen W. Saakvitne, PhD, Chair  
Independent Practice, Northampton, MA

Laurie Anne Pearlman, PhD  
Trauma, Research, Education, and Training Institute, New Britain, CT  
*Therapist-Initiated Terminations of Long-Term Trauma Therapies*

Christine A. Courtois, PhD  
Christine A. Courtois, PhD & Associates, PLC, Washington, DC  
*Risk Management and Ethics Issues in Termination of Long-Term Psychotherapy*

Karen W. Saakvitne, PhD,  
Independent Practice, Northampton, MA  
*Providing a Container for the Container: Consultation to Trauma Therapists*

## Poster Session

### Trauma Psychology—Special Populations and Special Issues

Saturday, August 16, 2008, 11:00AM–11:50AM  
Boston Convention and Exhibition Center Exhibit Halls A and B1

Michael J. Hirschel, BS, University of Mississippi, University, MS  
*Studying Hurricane Katrina: PTSD, Self-Efficacy, and the Mississippi Gulf Coast*

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## Convention Program Preview

*continued from p. 23*

Katherine M. Ryan, MS, Northwestern State University,  
Natchitoches, LA  
*Secondary Traumatization and Parental Attachment: Impact on  
Addictive Behaviors*

Troy W. Ertelt, BA, University of North Dakota, Grand Forks,  
ND  
*Effect of Perpetrator Age on Defining Behavior as Sexual Abuse*

Paul R. King Jr., MA, University of New York at Buffalo,  
Buffalo, NY  
*Differential Reporting of Trauma-Related Symptoms in Veterans  
With TBI*

Alexander S. Murray, University of Oregon, Eugene, OR  
*Effects of Childhood Trauma on Adult Psychopathology*

Sheeva M. Mostoufi, BS, VA Boston Healthcare System,  
Boston, MA  
*Psychophysiological Arousal, Disengagement Coping, and PTSD  
Symptoms: A Moderating Relationship?*

Pamela G. Gudino, MPH, Stanford University, Palo Alto, CA  
*Trauma and Depression Among Women Living With HIV/AIDS*

Raluca M. Gaher, MS, University of South Dakota, Vermillion,  
SD  
*Alexithymia as a Predictor of Coping Style in a Sample of  
Veterans Who Experienced Military Sexual Trauma*

Dara R. Goldberg, MS, VA Palo Alto Health Care System,  
Menlo Park, CA  
*Associations Between Posttraumatic Stress Disorder Factors and  
Criminal Offending*

Beryl Ann Cowan, PhD, JD, Children's Hospital Boston,  
Boston, MA  
*Trauma Exposure and Behavioral Outcomes in Sheltered  
Homeless Children: The Moderating Role of Perceived Social  
Support*

Judith A. Stein, PhD, University of California—Los Angeles,  
Los Angeles, CA  
*Impact of Hurricane Katrina on Delinquency Among Adolescent  
Female Offenders*

Samantha L. Slaughter, MA, Argosy University, Seattle, WA  
*Intergenerational Trauma in Vietnam War Veterans: A Model*

Paul J. Harrigan, PhD, Bath VA Medical Center, Bath, NY  
*Relationships Among Shame, Guilt, Social Cognitions, and PTSD  
Among Veterans*

Katie M. Edwards, MS, Ohio University, Athens, OH  
*Women's Stay or Leave Decisions in Sexually Abusive  
Relationships: A Narrative Analysis*

Shana Franklin, BA, Massachusetts General Hospital, Boston,  
MA  
*Traumatic Experiences in Individuals With Body Dysmorphic  
Disorder*

Carli M. Moncher, MA, Northern Arizona University,  
Flagstaff, AZ  
*Incident-Specific and Global Self-Blame in Sexual Assault  
Adjustment*

Lauren C. Drerup, MA, University of Kansas, Lawrence, KS  
*Family Environment, Personality, and Psychological Symptoms in  
Sexually Abused Individuals*

Eric C. Wood, PhD, University of North Texas, Denton, TX  
*Attachment, Fear of Intimacy, and Cognitions Among Child  
Molesters*

Robyn L. Gobin, BA, University of Oregon, Eugene, OR  
*Trust and Revictimization Among Betrayal Trauma Survivors*

Adam D. Brown, MA, New School for Social Research, NY,  
NY  
*Anger, Aggression, and PTSD Among Iraq and Afghanistan  
Combat Veterans*

Tanya Vishnevsky, BA, University of North Carolina at  
Charlotte, Charlotte, NC  
*Core Beliefs Inventory: Effects of Trauma on Assumptive World  
Beliefs*

David L. Meyer, PhD, VA Boston Healthcare System, Boston,  
MA  
*Preliminary Report on Prospective Firefighter Recruit Study*

Irina A. Komarovskaya, MEd, BA, University of Virginia,  
Charlottesville, VA  
*Trauma Model of Violence: Exploring the Relationship Between  
Past Trauma and Current Violence and Victimization in Prison*

Cristin D. Runfola, BA, Pacific Graduate School of  
Psychology, Redwood City, CA  
*Mental Health Outcomes in Sexually Exploited Foster Youth*

Christopher J. Monahan, BA, University of Memphis,  
Memphis, TN  
*Trauma Exposure and PTSD Symptoms Among Heavy-Drinking  
College Students*

Candice T. Norcott, MA, University of Connecticut, Storrs, CA  
*Schema Model of Trauma Adaptation Among Ethnically Diverse  
Women*

Lauren P. Ashbaugh, MEd, University of Virginia,  
Charlottesville, VA  
*Inmate Sexual Abuse Experiences: Incidence, Gender Differences,  
and Revictimization*



Rachel B. Needle, PsyD, Independent Practice, West Palm Beach, FL

*After the Trauma: Examining the Current Sexual Health Among Survivors of Interpersonal Abuse*

Kimberly A. Copeland, PsyD, Regent University, Virginia Beach, VA

*Sexual Trauma, Forgiveness, and Health*

Adena Steinberg, MA, Adelphi University, Garden City, NJ  
*Resilience, Attachment, and Depression in Bereavement*

Anthony P. Kontos, PhD, MA, Humboldt State University, Humboldt, CA

*Physical Activity, Hostility, Coping, and PTSD Following Hurricane Katrina*

Alison S. Cole, MS, State University of New York at Binghamton, Binghamton, NY

*Differential Adjustment Among Sexual Assault Survivors: Predicting Positive Outcome*



## Symposium

### Commonalities and Divergences in Dissociation Across Various Populations

Saturday, August 16, 2008, 12:00PM–1:50PM  
Boston Convention and Exhibition Center Meeting Room 254A

Jan Faust, PhD, Chair  
Nova Southeastern University, Fort Lauderdale, FL

Jan Faust, PhD  
Nova Southeastern University, Fort Lauderdale, FL  
*Role of Peer Sexual Abuse and Family Conflict in Dissociation*

Dawn M. Hughes, PhD  
Independent Practice, New York, NY  
*Difficulties and Dilemmas When Dissociation Is Present in Forensic Cases*

Charles R. Figley, PhD  
Florida State University, Tallahassee, FL  
*Dissociation: Implications of a New Paradigm of Combat Stress Injuries*

Steven N. Gold, PhD, Discussant  
Nova Southeastern University, Fort Lauderdale, FL

## Discussion

### Trauma-Related Issues in National Security Interrogations

Saturday, August 16, 2008, 2:00PM–3:50PM  
Boston Marriott Copley Place Hotel Wellesley Room

Robert Geffner, PhD, Chair  
Alliant International University–San Diego, CA

Nnamdi Pole, PhD,  
University of Michigan, Ann Arbor, MI

Gilbert Reyes, PhD

Fielding Graduate University,  
Santa Barbara, CA

Ibrahim A. Kira, PhD,  
University of Michigan, Dearborn  
MI

Sue L. Grand, PhD  
Independent Practice, Teaneck,  
NJ

Riccardo Rivas, PhD  
Independent Practice, Naples, FL

Julian D. Ford, PhD  
University of Connecticut, Storrs,  
CA

Morgan T. Sammons, PhD  
Alliant International University—San Francisco, CA

Shara Sand, PsyD, Discussant  
Yeshiva University, New York, NY

## Presidential Address

### Traumatic Effects of Violence and Abuse in Relationships

Saturday, August 16, 2008, 4:00PM–4:50PM  
Boston Marriott Copley Place Hotel Dartmouth and Exeter  
Rooms

Judie Alpert, PhD, Chair  
New York University, New York, NY

Robert Geffner, PhD  
Alliant International University, San Diego, CA

## Business Meeting

Saturday, August 16, 2008 5:00PM–5:50PM  
Boston Marriott Copley Place Hotel Dartmouth and Exeter  
Rooms

Robert Geffner, PhD, Chair  
Alliant International University, San Diego, CA

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## Convention Program Preview

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### Paper Session

#### Trauma Treatment Interventions

Sunday, August 17, 2008, 9:00AM–9:50AM

Boston Convention and Exhibition Center Meeting Room 157B

Carla S. Stover, PhD

Yale Child Study Center, New Haven, CT

*Child and Family Traumatic Stress Intervention: Preliminary Evidence of PTSD Prevention*

Richard M. Kagan, PhD

Parsons Child and Family Center, Albany, NY

*Real Life Heroes: Attachment-Centered Treatment for Children With Traumatic Stress*

Albert Rizzo, PhD

University of Southern California, Marina del Ray, CA

*Virtual Iraq: VR PTSD Exposure Therapy With Iraq War Combatants*

Lindsay M. Orchowski, MS

Ohio University, Athens, OH

*College Women's Perceptions of Risk to Experience Sexual Victimization*

Elizabeth A. Yeater, PhD

University of New Mexico, Albuquerque, NM

*Sexual Attitudes and Sexual Victimization History Affect Women's Response Refusal*

Katie M. Edwards, MS

Ohio University, Athens, OH

*College Women's Stay or Leave Decisions in Sexually Violent Relationships*

Megan E. Crawford, MS,

University of Georgia, Athens, GA

*Applicability of Pennebaker's Writing Paradigm to Survivors of Sexual Trauma*

Karen S. Calhoun, PhD, Discussant

University of Georgia, Athens, GA

### Symposium

#### Risk Factors for Sexual Victimization—Implications for Treatment and Intervention

Sunday, August 17, 2008, 10:00AM–11:50AM

Boston Convention and Exhibition Center Meeting Room 160A

Christine A. Gidycz, PhD, Chair

Ohio University, Athens, OH

Danielle R. Probst, MS

Ohio University, Athens, OH

*Impact of Childhood and Adolescent Trauma on Adult Sexual Victimization*

### Discussion

#### Town Hall—Reducing Interpersonal Violence: Planning for the Future

Sunday, August 17, 2008, 12:00PM–1:50PM

Boston Convention and Exhibition Center Meeting Room 160A

Alan E. Kazdin, PhD, Chair

Yale University, New Haven, CT

Robert Geffner, PhD

Alliant International University, San Diego, CA

Jacquelyn White, PhD

University of North Carolina at Greensboro, Greensboro, CA

## 2008 Division 56 APA Convention Hospitality Suite Schedule

Note: the hospitality suite will be in the Marriott Copley Hotel. The room number is to be determined.

Thursday, August 14

- 5 pm to 11 pm—Executive Committee Meeting, Part 1

Friday, August 15

- 9 am to 10 am—Special Interest Group 18
- 12 pm to 1 pm—Student Brown Bag Discussion
- 6 pm to 7 pm—Dissociation Special Interest Group

Saturday, August 16

- 1 pm to 3 pm—Diversity Discussion
- 8 pm to 11 pm—Executive Committee Meeting, Part 2





Elizabeth Carll, PhD

## International Committee

*Elizabeth Carll, PhD, Chair*

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

## Giving Trauma Psychology Away on Wikipedia

*Jennifer J. Freyd, Professor of Psychology, University of Oregon, and Chair, Division 56 Science Committee*

Research and professional psychologists have long agreed to share the responsibility to *give psychology away*. This duty implies an educational mandate to make our research and theory available to the public.

At the moment, one powerful way psychology is communicated to the public is through the shared web-based encyclopedia, Wikipedia. With a software base (a Wiki) that allows users to edit entries, Wikipedia is an encyclopedia written collaboratively by contributors around the world. Anyone can add or edit entries. Wikipedia is the first place people, including students, look for information. This often occurs because Googling a psychological term will result in a Wikipedia page as the first site. For many domains the quality of the information on Wikipedia is good, but for the domain of trauma psychology, there is currently a lack of accurate information and even, in some cases, misleading and inaccurate information. As members of Division 56 it is our duty to correct this problem—to give trauma psychology away on Wikipedia.

In addition to contributing to Wikipedia ourselves, the teachers amongst our group also can teach our students to take responsibility to edit this collaborative encyclopedia. During our winter 2008 term I taught a graduate seminar at the University of Oregon called, “Understanding Childhood Trauma: Historical and Societal Contexts.” One of the required assignments in this seminar for each of the 14 participants was to lead or co-lead a class discussion and then to either post a summary of that discussion on the course website or to edit a Wikipedia page. The particular assignment I gave my students was the following:

### *Wikipedia Alternative Assignment*

*An alternative to the discussion summary requirement is to edit a Wikipedia page (by deadline of discussion points posting requirement). If you select this alternative, you need to email [the instructor] the specifics. Also it would be great if you posted details of the edit on the class on-line discussion board. See these pages for how to edit Wikipedia: [http://en.wikipedia.org/wiki/Wikipedia:How\\_to\\_edit\\_a\\_page](http://en.wikipedia.org/wiki/Wikipedia:How_to_edit_a_page) and [http://en.wikipedia.org/wiki/Category:Wikipedia\\_editing\\_guidelines](http://en.wikipedia.org/wiki/Category:Wikipedia_editing_guidelines)*



Jennifer J. Freyd

In class I explained that the students would not be graded on the quantity or quality of the edits but rather receive full credit simply for having done the assignment. Only one student had ever edited Wikipedia before participating in this class. Ten of the 14 students elected to edit a Wikipedia page. The students who selected this alternative expressed great enthusiasm for it. They learned how to contribute to this world-wide collaborative project and they felt a sense of accomplishment in adding important information or correcting errors. My students chose a variety of pages to edit including pages regarding the treatment of child abuse, child sexual abuse, day care sexual abuse cases, and imaginary friends. At the end of the course, students described the Wikipedia editing experience as empowering and satisfying.

Early in the seminar I had explained to my students that controversial topics are often vulnerable to “editing wars” on Wikipedia, so that they should be aware that their edits could be removed very soon after they were added. I explained that certain guidelines on Wikipedia can be used wisely. For instance, when noticing an unbalanced perspective, an edit that is both educational and has better probability of remaining on the page is one that includes information about the controversy over the topic and provides a link to a different perspective. That link could be a web page maintained by the author or someone else that is not subject to external editing. For example, two of my former graduate students noted problems with information on memory for trauma and have thus created a web page “Common Myths about Memory for Trauma” (<http://dynamic.uoregon.edu/alum/myths.html>) that can be used as a link inside Wikipedia entries.

Providing accurate information to the public is a professional duty we all share. Millions of people check Wikipedia for information on a daily basis and the need for accurate trauma psychology information is vast. Contributing wisely to Wikipedia is a way we can quickly fulfill this important responsibility to educate and give information on trauma psychology away.

# Secondary and Vicarious Trauma SIG

Sara Maltzman, PhD, SIG Chair



Sara Maltzman, PhD

The Secondary and Vicarious Trauma SIG was approved by our Division 56 Executive Committee in March 2008. Our SIG unites psychologists interested in research and practice regarding secondary and vicarious trauma and strategies to mitigate their effects, at both the individual and organizational level. Our members have a variety of interests and professional backgrounds, representing established faculty and researchers, practitioners in private practice, professionals in public sector/non-profit settings, and students/new professionals starting careers.

A SIG meeting will be held during the APA convention in Boston in the Division 56 Hospitality Suite on Friday, August 15, from 9:00 a.m. to 10:00 a.m. Everyone interested in the SIG is welcome to attend! We will be brainstorming how best to focus our energies and meet the needs and interests of our members. Some ideas for discussion include:

- Hosting symposia at future conventions
- Formally develop resource lists for our members
- Consider developing additional formal positions within the SIG
- Developing formal collaborations with other specific APA Divisions, Sections, and/or SIGs

Graduate students, in particular, are encouraged to attend. If you would like additional information about our SIG, please do not hesitate to contact me at smaltzman@cox.net. Hope to see you in August!

## BOOK REVIEWS **Operation Homecoming: Iraq, Afghanistan and the Home Front, in the Words of U.S. Troops and Their Families**

*National Endowments for the Arts. (2006). Andrew Carroll, Editor. New York, Random House. ISBN-10: 1-4000-6562-3 \$26.95*

Reviewed by Jaine Darwin, PsyD



Jaine Darwin, PsyD

As I write this review, we are marking the fifth anniversary of the launch of Operation Iraqi Freedom (OIF), an offensive that expanded the Global War on Terrorism, begun in Afghanistan, Operation Enduring Freedom (OEF), precipitated by the atrocities of 9/11/01. According to the military, as of January, 2007, 1.6 million soldiers had deployed a total of 2.2 million times to serve in a war in which less than 2% of our nation's population are serving. Operation Homecoming, an anthology of prose, poetry, and fiction written by members of the military and their families, brings the affective reality of their experience to the public eye and puts a human face on what can easily be a war involving nameless, faceless soldiers fighting a war for which many have no affinity. The narratives allow the reader an immersion in the experiences and consequences of war for soldiers and those who love them.

This book grew out of a project sponsored by the National Endowment for the Arts; the NEA sent professional writers to conduct writing workshops on military bases to help soldiers who served in the Global War on Terrorism create verbal records of their subjective experiences. The content takes the reader from the first attacks of 9/11 to serving at the front, or as the soldiers say, the Sandbox, to the readjustment of return or the pain for the family members

when the soldier fails to return because of mortal wounds or is so changed by catastrophic injuries as to feel lost to the family.

As all of us who study and treat traumatized people know, the ability to metabolize the impact of trauma is increased when the survivor can use words to tell the story. It is to this end that people can bear witness and find ways to speak about the unspeakable.

This collection of writings ranges from the heroic to the mundane, from the heartbreaking to the ironic. The works by family members shows that, to borrow from Winnicott, there is no soldier without a family. When a soldier serves, the whole family serves with them, coping with the strain of the absence, the fear, the additional responsibilities and the burdens of long range communication. For families of national guard and reservists, they serve in isolation without the support of a military base. Parents and siblings of active duty military may also experience similar tensions.

Officers and high-ranking non-commissioned officers contributed the majority of writing for this book. One wonders what happens to the many who lack the verbal facility to utilize writing as an outlet. As the military lowers the criteria for enlistment, how do these others cope and heal? Our volunteer military is a reflection of class distinctions in our society. Many join the military to escape from troubled homes, neighborhoods rife with violence, as a means of upward mobility. The brief biographical notes about the officers whose work appears in this collection tend to be better educated and come from socio-economically advantaged upbringings.

Along with Kenneth Reich, Ed.D., I co-direct SOFAR: Strategic Outreach to Families of All Reservists. We offer pro-bono support, psychotherapy, psycho-education and prevention services to and extended family of national guard and reserve who serve in Afghanistan and Iraq from deployment through reunion and reintegration. Many of our families are awaiting the third deployment of their soldier.

The time at home between deployments has been marked by nightmares, emotional absence, irritability, and emotional lability. According to a mental health task force report from the Department of Defense, 50 % of national guard and reservists, 40% of active duty military and 31% of Marines return from combat with a diagnosable mental health condition. 53% of suicides of returned veterans were national guard and reserve members. In our work with families, we attempt to normalize what they are feeling; that anger at being left home with three small children will not cause harm to the soldier; that happiness is not a betrayal; that relief that the death notification team knocked on someone else's door does not make someone heartless.

I applaud the efforts of the NEA, but I'd like to see them widen the circle to include these families. I would like to see writings by those who may need to learn that language brings relief before they even attempt to react rather than enact. I would like the 98% of the population who do not serve to bear witness to the pain of these children. As professionals committed to working with trauma, we know that, untreated, trauma has a long tail that may impact generations. Telling the tales of the angst and the anger, valorizing their resilience, will raise the public awareness so the cycle of intergenerational transmission of trauma may be stopped.

## 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).

## Trauma and Human Existence: Autobiographical, Psychoanalytic, and Philosophical Reflections

by Robert D. Stolorow

[*Psychoanalytic Inquiry Book Series Volume 23*]  
The Analytic Press (2007)

Reviewed by Marilyn S. Jacobs, PhD, ABPP

"Knowledge is in the end based on acknowledgment."  
—Ludwig Wittgenstein (*On Certainty*)

Robert D. Stolorow's new book, *Trauma and Human Existence: Autobiographical, Psychoanalytic, and Philosophical Reflections*, is a poetic and deeply poignant study of psychological trauma. The work is richly nuanced, yet at a mere 50 pages of text, elegantly brief. It is a remarkable addition to the trauma literature and stands to become an essential volume in the library of anyone seeking to understand trauma.

The concept of trauma is the cornerstone to psychotherapy theory and practice and may have been historically what legitimized the mental health professions. Since the second half of the 20<sup>th</sup> century, trauma has been frequently interpreted according to the biopsychosocial model as a psychological condition with physical symptoms provoked by a catastrophic experience that overwhelms the person's ability to cope with the thoughts and feelings that relate to that experience. Trauma symptoms are categorized into psychiatric disorders that require treatment. Recent advances in neurobiology and



Marilyn S. Jacobs, PhD, ABPP

the advent of psychotropic medications have provided traumatized individuals with helpful pharmacotherapeutics. Psychological therapies have also increased therapeutic effectiveness. The goal of treatment is often understood as the restoration of the traumatized individual's ability to function and the integration of the traumatic experience to reduce suffering. This professional tradition is what we know and how we have worked with our traumatized patients.

Yet, after reading this book, one is inclined to think that, all along, something has been missing in our knowledge of psychological trauma, something that we did not know but that we needed to know. And, thanks to Robert Stolorow, now we know.

*Trauma and Human Existence* is particularly unique as it does not focus upon either the nosological classification of traumatic conditions, the specific physical and psychological symptoms of trauma, or evidence based etiological or treatment research on populations based upon psychobiological models. Instead, the work applies a phenomenological perspective to explain the experience of trauma at its deepest levels of meaning. It brilliantly synthesizes insights from psychoanalytic psychology and phenomenological philosophy and in doing so provides the reader with an experience-near understanding of the complexities and vicissitudes of psychological trauma. And, perhaps most importantly, the work explores how the phenomenology of trauma is not only a clinical disorder to

continued on p. 30

## Trauma and Human Existence

*continued from p. 29*

be found in our traumatized patients, but affects all of us, and potentially can occur at any time, and is ultimately also inevitable in all of lives. We are all inherently traumatized by the nature of our existence.

The author has integrated wisdom from psychoanalytic intersubjectivity theory, the philosophy of Martin Heidegger, the author's personal experience of traumatic loss, and compelling case vignettes. He also compares and contrasts classical and contemporary psychoanalytic theory. Epigraphs from poetry, philosophy, psychoanalysis, and folk music provide lovely illuminations to the content of the chapters. The work elegantly manages to convey a profound mastery of the nuances of trauma in a manner in which no prior work has achieved.

Robert Stolorow has been at the forefront of the contemporary relational turn in North American psychoanalysis for the past three decades. During this time, his scholarship has evolved as he has traced the complexities of the subjective structures of psychological experience. His intersubjectivity theory, with its crystalline language and enduring relevance, has recast psychoanalysis. He has had a profound and lasting influence on a generation of psychoanalysts. Stolorow is the author or co-author of nine books and one hundred and eighty articles that consider affect, emotion, trauma, experience, and the process of psychoanalytic therapy. His journey of understanding in these areas has included an active role in the entities that have debated these ideas. He has been the founder of several psychoanalytic organizations, has served on the editorial boards of several psychoanalytic journals, and is a continued intellectual presence in psychoanalysis as a teacher, presenter, and supervisor. This most recent commitment to psychological inquiry, *Trauma and Human Existence* may well be regarded as being his most elegiac and refined work.

In the book, Stolorow extends his intersubjective/contextual model of the mind to develop two central themes—"the contextuality of emotional life in general and the experience of emotional trauma in particular" and the "the recognition that the possibility of emotional trauma is built into the basic constitution of human existence" (p. xi).

Chapter 1: "The Contextuality of Emotional Life" sets the stage for the development of a unitary theory of trauma. Here Stolorow contrasts the phenomenological contextualism of intersubjective-systems theory in psychoanalysis to the isolated Cartesian subject and determinism of classical psychoanalysis. He introduces the philosophy of Martin Heidegger, with its view of human life as deeply embedded "in-the-world," as "perhaps the most important challenge to the Cartesian subject" (p. 2). We are our context, and this is disclosed in three modes; affectivity, understanding and discourse. To understand psychological trauma, one must understand affect and especially unbearable affect. In the psychoanalytic process, the consequences of developmental trauma are understood through the therapeutic impact of affective attunement and interpretive understanding.

Chapter 2: "The Contextuality of Emotional Trauma" traces the concept of trauma in psychoanalytic thought.

Freud's conception of trauma was a "reified image of an isolated, faltering mental apparatus, unable to process the instinctual energies flooding it from within its own depths" (p. 9). This is the Cartesian isolated-mind view of human mental experience. In contrast, Stolorow understands trauma to be "an experience of unbearable affect" (p. 9), which is not only due to the intensity of the feelings created by the inciting event but to an experience that occurs in an intersubjective situation where "severe emotional pain cannot find a relational home in which it can be held" (p. 10). The result of an insufficient relational context for the integration of painful affect is the dissociation of painful emotions from experience, which can lead to psychosomatic states or splits in the subjective experience of mind and body. It follows that in psychoanalytic treatment, the inevitable remobilization of painful vulnerabilities and traumatic states contributes to the patient's attitude of defensive resistance towards the therapist and thus to denial.

Chapter 3: "The Phenomenology of Trauma and the Absolutisms of Everyday Life" elaborates upon the author's own personal experience of traumatic loss with the sudden death of his wife, which led him to grasp "the experiential chasm separating the traumatized person from other human beings" (p. 14). As well, he reflects upon "the profound despair about having one's experience understood" that lies in the essence of emotional trauma. And he concludes that the worlds of normals and those of traumatized ones are so different that they cannot be compared—"essentially and ineradicably incommensurable" (p. 15). The traumatized individual is supremely aware of those aspects of human existence which are not a usual component of the normal everyday absolutisms that are taken for granted and shared by those who are not traumatized. Consequently, "an anguished sense of estrangement and solitude takes form" (p.16) in the emotional world of those traumatized.

Chapter 4: "Trauma and Temporality" begins with four clinical vignettes that vividly illustrate the isolating effect of emotional trauma on the traumatized individual's sense of time. The first of these vignettes will be recounted here as it is particularly relevant.

"The patient with a long, painful history of traumatic violations, shocks, and losses arrived at her session in a profoundly fragmented state. Shortly before, she had seen her psychopharmacologist for a 20-minute interview. In an apparent attempt to update her files, this psychiatrist had required the patient to recount her entire history of traumatization, with no attention given to the emotional impact of this recounting. The patient explained to me that with the retelling of each traumatic episode, a piece of herself broke off and relocated at the time and place of the original trauma. By the time she reached my office, she said, she was completely dispersed along the time dimension of her crushing life history. Upon hearing this, I spoke just three words: 'Trauma destroys time.' The patient's eyes grew wide; she smiled and said, 'I just came together again'" (p. 17).

Stolorow enlarges the conceptual basis of his discussion with the addition of the phenomenology of time found in the work of Husserl and Heidegger. Husserl considered phenomenological time as being at the core of lived experience. The normal psyche has a sense of time in

which past, present and future are united—what Heidegger called “the ecstatic unity of temporality” (p. 19). This temporality makes our existence meaningful. This stretching between past and future is what is “devastatingly disturbed by the experience of emotional trauma” (p. 20). Traumatic experiences become “freeze framed into an eternal present” to which “one is condemned to be perpetually returned” (p. 20). And here Stolorow gives us a profound insight; “it is trauma, not the unconscious that is timeless” (p. 20).

Chapter 5: “Trauma and the ‘Ontological Unconscious’” is the most moving chapter as Stolorow details his personal experience of traumatic loss after his wife died and how he attempted to cope with living with this loss. Here he introduces the concept of “the ontological unconscious” (p. 26)—the loss and deadening of one’s sense of being due to the loss of a “relational home” for the painful affects of the traumatic experience. He then provides a review of his prior work with his collaborators George Atwood and Donna Orange regarding the differing contextual views of unconscious experience. He references Henry Krystal’s thinking relating to affect and emotional experience to point out that “Linguisticity, somatic affectivity, and attuned relationality are constitutive aspects of the integrative process through which the sense of being takes form” (p. 30). To understand traumatic experience, one must understand “that it is in the process of somatic-symbolic integration, the process through which emotional experience comes into language, that the sense of being is born” (p. 30). The disruption of the individual’s ability to have a language for emotional experience and to have a context to articulate that language will create the loss of a sense of being. And “the loss of a sense of being is, in fact, a loss of being” (p. 30).

Chapter 6: “Anxiety, Authenticity, and Trauma” is a thought-provoking essay on anxiety. The conclusion that “the possibility of emotional trauma is inherent to the basic constitution of human existence” (p. 34) leads one to agree with Stolorow that “Heidegger’s interpretation of anxiety ... is ... unsurpassed in the psychoanalytic literature” (p. 35). Emotional trauma plunges the traumatized person into recognition of death as a constantly threatening possibility, leading to the “collapse of everyday significance and the resulting feelings of uncanniness” (p. 35). These feelings are normally covered up and evaded. When one is traumatized, one can no longer have a normal sense of being-in-the-world. Trauma is singularizing, isolative, and non-relational, and its terror unendurable. It propels one toward knowing one’s own and others’ finitude and the prospect of inevitable death and loss. This experiential knowledge cannot be disowned as a possibility when one is in a traumatized state. But it cannot be fully integrated unless a relational home for the experience can be found, thus restoring one’s sense of being.

Chapter 7: “Siblings in the Same Darkness” is the concluding chapter. Stolorow writes, “In virtue of our finitude and the finitude of our important connections with others, the possibility of emotional trauma constantly impends and is ever present” (p. 47). He then attempts a reconciliation of the book’s two contradictory ideas—the context dependent nature of emotional trauma and the a priori inevitability of emotional trauma in human life. Using several poignant personal examples, Stolorow elaborates on the idea that,

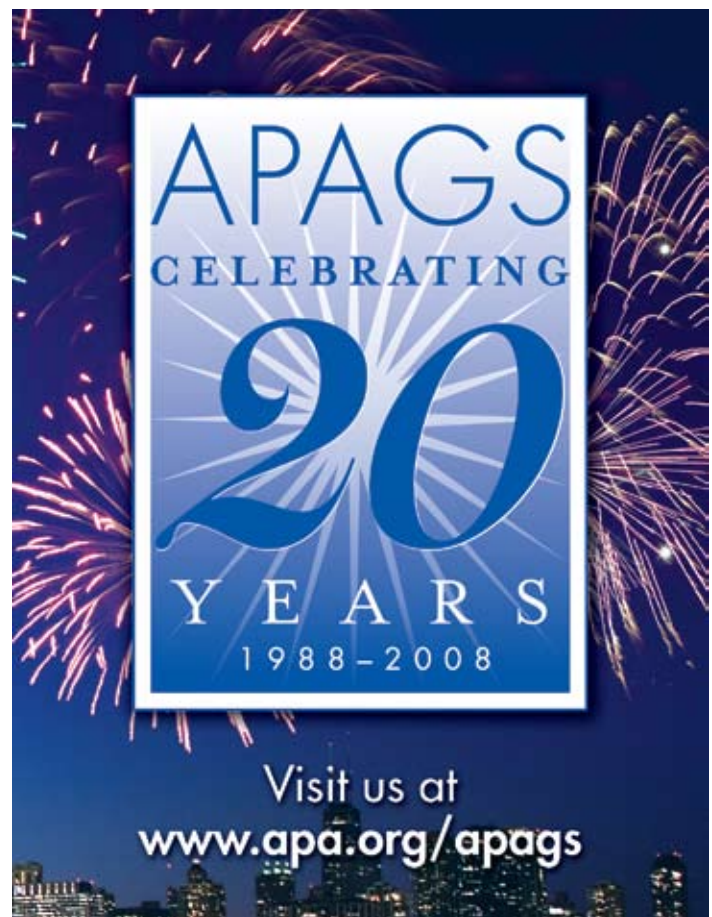
“although the possibility of emotional trauma is ever present, so too is the possibility of forming bonds of deep emotional attunement within which devastating emotional pain can be held, rendered more tolerable, and, hopefully, eventually integrated” (p. 49). The “possibility of emotional trauma is constitutive of our existence and of our being-with one another in our common finitude” (p. 50).

*Trauma and Human Existence* is a work that will be read many times over by those who first encounter it, with new wisdom to be discovered with each reading. It is succinct, yet incisive and stirring. It leaves a lasting impression. We are indebted to Robert Stolorow for his intelligible and practical interpretation of phenomenological philosophy as it relates to the clinical work with traumatized patients. Furthermore, his synthesis of this philosophical canon with contemporary psychoanalysis is an enduring contribution to the trauma literature.

We are also reminded by this work of the relevance of intellectual pluralism in psychology and in psychoanalysis and the relevance to our work when our paradigms are constructed from the wisdom of many areas of knowledge—including our own experiences.

This work is highly recommended as essential reading for psychologists, psychiatrists, social workers, and anyone else who seeks a definitive understanding of the nature of human psychological trauma and the possibilities for its effective treatment.

*Marilyn S. Jacobs, PhD, ABPP, is a clinical psychologist and psychoanalyst in private practice in Los Angeles, CA.*



## Moving the Trauma Field Forward

continued from p. 1

As part of our efforts to also move the field forward within and outside of APA, we have already appointed five (5) task forces that deal with various trauma issues, three were appointed in 2007, and two more in 2008. Each of these task forces will be in place for at least two years.

One task force is actively engaged with the issues of torture and coercive interrogations, which have had a profound impact on the field of psychology in recent years, with respect to both ethics and trauma. In addition to causing deep divisions within APA, these issues have led some colleagues to withhold APA dues or to resign completely from the organization. This task force deals with the issues from the perspective of trauma, and task force members will be featured at a symposium and discussion session at the convention in August in Boston.

A second task force is providing input to *DSM V* concerning the diagnosis of post-traumatic stress disorder (PTSD), and the issue of including complex trauma as a separate diagnostic category. Clinicians and trauma researchers are clear that PTSD is not only a clinical diagnosis but is also increasing as a result of world and national events, yet there is now some question about even including it in *DSM V*. It is always interesting to me from a social psychological perspective, how many people tend to want simple answers to major problems, and when that does not work, instead of exploring the roots of the problem, some say there is no problem. I think this may be called denial (or substitute the defense mechanism of your choice here). PTSD has been especially noteworthy with military personnel returning from Iraq.

The newspapers and media have continually reported research indicating that high rates of PTSD and suicide have affected large numbers of returning veterans. At the same time, there has been a political push by some members of the current governmental administration and others to eliminate the diagnosis of PTSD and to reduce services and benefits for those individuals who are affected by PTSD and their families. The "solution" then, according to these people, is to cut services and programs by eliminating the diagnosis. Thus, Judie Alpert set our third task force to deal with these trauma issues for military veterans and their families.

Two new task forces begin work this year. The first one deals with the ethical role of psychologists dealing with trauma and abuse in forensic settings.

Being a forensic psychologist, among the various hats I wear, it is amazing to me how many psychologists either testify as expert witnesses in cases involving trauma or abuse issues, or actually conduct some type of evaluation in these types of cases even though they have little or no expertise in trauma or abuse. I recently reviewed a forensic evaluation in a child custody case, in which the victim of intimate partner abuse and her children indicated that they were exposed to abuse for many years. These were significant allegations of trauma, yet the licensed clinical psychologist did not assess the children, administered an MMPI to the parents, interviewed the parents, briefly interviewed the children, but did not review significant collateral records, interview collateral sources, explore in depth any of the alleged acts of abuse, or administer any other psychological tests or trauma inventories to any of the parties. The psychologist claimed to have expertise in



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these issues as a result of conducting 100 such evaluations, and had indeed taken one workshop dealing with intimate partner violence over 10 years ago. The psychologist could not identify any of the trauma measures (such as the Trauma Symptom Inventory for adults or Trauma Symptom Checklist for children), did not know any way of assessing for abuse, had not read or subscribed to any of the more than 15 journals that focus specifically on trauma and/or maltreatment, and could not recall having attended any workshops specifically on any of these issues in the past 5 years. Yet to the court, this psychologist claimed expertise in the field of trauma, while at the same time completely omitting trauma or abuse issues from all conclusions and recommendations concerning how and where these two children should spend the next 10–12 years of their life. Thus, this task force will focus on ethical practices for psychologists dealing with trauma and abuse in forensic settings. It will have representatives from other divisions, and make recommendations on how we can help eliminate this problem that tarnishes the reputation of all psychologists.

The fifth task force will continue the Division's work on interpersonal violence. The APA Summit on *Violence and Abuse in Relationships: Connecting Agendas and Forging New Directions* that took place in Washington, DC, last February was quite successful (see p. 5 for a report by Sylvia Marotta)!! Jackie White, President of Division 35 (Psychology of Women) and I, President of Division 56, co-chaired this event, which was co-sponsored by both divisions. When we initially planned for this Summit, as part of Alan Kazdin's APA Presidential Initiative, we hoped 300 people would attend. However, 19 divisions became involved as collaborators, as well as several national organizations and agencies, and 450 people registered!! Building on this success, it was decided that this

would be the first in a series of events whose goals are to reduce interpersonal violence and to shape policies, research and practice. Therefore, this task force has been formed to support these projects. The Summit will become a bi-annual event in even numbered years (the APA Multicultural Summit occurs in odd-numbered years); Steve Gold, our President-Elect, is co-chairing a thematic organization of presentations dealing with interpersonal violence in several divisions throughout the APA convention in August; a think tank on how to integrate research, practice and policy will occur just prior to the International Conference on Violence, Abuse and Trauma in San Diego in September (see announcement on p. 8); and a five-year action plan will be developed. It is hoped that Reducing Interpersonal Violence will also become an important part of the APA's overall strategic plan.

The above does not even include the three interdivisional grants we are working on in our first year, the numerous special interest groups (SIG—chaired by Desnee Hall) that have already formed, or the important work already in progress by our various committees (see p. 2 for a list of Committees and Chairs). Thus, if you are reading this article and have an interest in any of these areas, you have a home in Division 56!! But more than a home, we want you to become actively involved as well, if possible.

- Join a SIG or a committee
- Attend the outstanding trauma sessions scheduled at the APA conference both in the regular program and at our hospitality suite program (a first, organized by Joan Cook and Richard Thompson)
- Contribute to the newsletter or our new journal.

I look forward to meeting you in August, and/or feel free to email me with any questions or comments.

Take care and be safe!



*Dr. Bob Geffner, President of Division 56, received an APA Presidential Citation from Alan Kazdin, President of APA, in February at the APA Summit on Violence, Abuse and Trauma. This citation was for his 30 years of work in the trauma and human aggressions fields, for mentoring many colleagues and students, for his service to many committees and divisions of APA, including the co-chairing of the Summit, and for his publications, research, and advocacy to reduce violence and abuse.*

## In Libraries and Bookstores



Kathy Kendall-Tackett

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

## Save the Date!

**116th Annual APA Convention**

**Boston, Massachusetts**

**August 14–17, 2008**

# Mission of Division 56

# Trauma Psychology

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

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

## Services to APA and its Membership

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

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

**Consideration and Integration:** Consideration and integration of diverse areas of study such as: combat, rape, domestic violence, child physical and sexual abuse,

refugee, torture survivors, prisoners of war, community violence and occupational traumatic stress; exploration of underlying principles leading to the development of psychopathology, disability and distress, resilience, and mental and physical health; integration of clinical knowledge and research.

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

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

**Prevention:** Develop and support prevention research and practice.

**Public Education:** Projects working towards public education. **Publications:** Producing materials on a wide range of trauma-related topics.

## Membership Benefits

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

Yes, I want to join Division 56!  
**MEMBERSHIP APPLICATION**

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- Member \$25  Professional Affiliate \$25
- Fellow \$25  Student Affiliate \$10
- Associate \$25

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Are you an APA member?  Yes  No

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- Check (Make check payable to "Division of Trauma Psychology, APA")
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## JOURNALS

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Journal of Trauma & Dissociation  
Journal of Aggression Maltreatment and Trauma (2 volumes annually)  
Journal of Child Sexual Abuse  
Journal of Emotional Abuse

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### EDITORIAL STAFF

#### EDITOR

*Topher Collier, PsyD*  
Steinhardt School of Education  
New York University  
The Park West Practice – Independent Practice  
115 Central Park West, Office 5  
New York, New York 10023  
Phone: (212) 675-2254  
Facsimile: (212) 579-3430  
DrTopherCollier@aol.com

#### ADVISORY EDITORS

*Elizabeth K. Carll, PhD,*  
*Advertising*  
ecarll@optonline.net

*Lisa M. Jones, PhD*  
lisa.jones@unh.edu

*Susan Grand, PhD*  
*Mass Media Reviews*  
dr\_sue\_grand@yahoo.com

*Kathleen Kendall-Tackett, PhD,*  
*Trauma and Health*  
kkendallt@aol.com

*L. Kevin Hamberger, PhD*  
kevinh@mcw.edu

*Toby G. Kleinman, Esq.*  
toby@adlerkleinman.com

#### EDITORIAL ASSISTANTS

*Andrew S. Frazee*  
Central High School  
Evansville, Indiana

*Frances McC. Doughty*  
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Newcastle upon Tyne  
United Kingdom

#### DESIGN/LAYOUT

*Micheline L. Meyers*  
APA Division Services

#### LOGO DESIGN

*Janet Perr*  
www.janetperr.com

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<i>Authors' Submission Deadline</i>	<i>Issue</i>	<i>Publication Date</i>
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