I am going to speak today about some very fundamental issues in the field of trauma psychology. In the interest of time, that will serve as the sum total of my introduction to my topic. I will launch directly into discussion the first of the four pillars of trauma psychology I will be discussing today: theory.

The entire field of trauma psychology is based on theory. The assertion—or assumption—that catastrophic events can have appreciable adverse impact on psychological functioning is itself a theoretical proposition. It is precisely for this reason that the fundamental conception in our field is a source of controversy.

If you find the proposition that our field is grounded in conjecture unsettlingly ambiguous, let me remind you that theory and theory building are an integral component of the scientific enterprise. We too easily forget as we go about our day to day professional endeavors is that implicit in this assertion is the notion that all science is ultimately built not solely on the
We are proud to announce that Div 56’s Trauma Psychology Newsletter is going electronic beginning with the Winter 2010 edition.

With escalating production and mailing costs and our commitment to eco-friendly efforts, this edition of TPN will be the last one you will receive on paper. Future versions of the newsletter will be delivered as a PDF file to your email inbox. We will also send out an announcement about newsletter issues as they are published on our website through our division’s announce-only listserv, div56announce@lists.apa.org.

While much-beloved Kermit the Frog first croons, “It’s not easy being green,” the Division 56 Council and Trauma Psychology Newsletter “staff” are hoping to make this an easy process for our members and readers. Here are a few simple steps to ensure that you don’t miss out on any upcoming issues or important happenings with the field of trauma psychology and Div 56:

Please make sure that your Membership with Div 56 is up-to-date and that your current email information is on file. We will automatically add emails to the listserv for paid memberships we have in our database that are NOT marked “stop bulk email.” If you have asked APA or the division not to send you emails, you will NOT be included.

If you’d like to be added to the listserv in any case, send a note to listserv@lists.apa.org and type the following in the body of the message: Subscribe div56announce. (Note that there are no spaces inside div56announce.) Do not include anything else in the body of the message and do not put anything in the subject line.

If you have any questions about your membership, the email address in your record, or listserv subscription, please contact Keith Cooke at division@apa.org or kcooke@apa.org.

If your email system requires special tweaking in order to accept attachments, please set your email preferences (or talk to your IT person on how to do so) to ensure that you can receive emails and attachments from our announce-only listserv, div56announce@lists.apa.org.

You can also always access PDF versions of the current newsletter, once posted, as well as all previous issues and archives, from the Division 56 website, www.apatraumadivision.org.

Division 56’s active efforts to make this “greener” shift with an electronic newsletter version has many benefits—saving trees, contributing to a more eco-conscious community, and cutting costs for production, printing and mailing. If these “perks” are not persuasive enough and you still wish to receive a paper copy, email your desire to receive a print copy via USPS mail to Keith Cooke at kcooke@apa.org or division@apa.org. With your request, please be sure to include your name, membership number, and complete mailing address.

Please remember, though, that an electronic version will arrive to members faster and allow quicker access to all that we offer, and provide a considerable financial savings to our division. And, as Kermit the Frog also reminds us:

“When green is all there is to be
It could make you wonder why, but why wonder why?
Wonder, I am green and it’ll do fine, it’s beautiful!
And I think it’s what I want to be.”
(From “The Sesame Street Book and Record.” “Green” is ©1970 Jonico Music, Inc.)

### Apportionment Ballots Needed

APA members will shortly be receiving their apportionment ballot. Please give ALL 10 OF YOUR VOTES to Division 56. If you can’t give us all 10, give us as many as you can. Ask your friends and colleagues who aren’t yet members of 56 to do so as well. Here’s why:

**Division 56’s representation on APA Council, which is APA’s decision-making body, depends entirely on what percentage of the apportionment vote that we get. We only need a few hundred more votes to get over the top to getting a second representative.**

Most APA members throw away their apportionment ballot, not realizing how important it is. An APA member need not belong to Division 56 to give us their vote—all votes count.

You can be proactive—contact your friends and colleagues who are APA members when you get your ballot and ask them to give 10 to 56.

Thanks!
Raising “Toddler” Divisions

Laura S. Brown, PhD, ABPP, President-Elect

Back in 1987, I was the fourth president of Division 44. What I learned then is standing me in good stead now that you’ve done me the honor of making me the fourth president of Division 56. I see APA’s divisions as having developmental stages, similar to those of humans, and Division 56, like Division 44 two decades ago, is a toddler of sorts. Division 56 is finding its feet, gaining quickly in cognitive capacities, and needing to deepen some of what it’s acquired in its first few years in order to grow well and strongly into the future.

So I see my job for the next year or so as helping us to deepen. Division 56 has come into being with a huge rush of energy and enthusiasm. Many of our members and leadership have long histories in the field of trauma psychology, and we are graced with some of the best, most innovative, and most productive minds in the field. It’s not often that a new division of APA is peopled by folks who’ve been the president or board members of related specialty organizations, but we’ve had past officers of ISTSS and ISST-D, and founding elders of our field, already on our executive committee. With such riches comes a fountain of ideas and possibilities, and an awareness of what can and must be done. Thus, in its few short years of existence our division already has a highly regarded journal and one of the most content-rich newsletters in APA, as well as active collaborations with many other groups inside and outside of organized psychology. Our membership is growing, and we have a good-sized group of early career psychologists (ECPs) and students active, too.

We are broad and energetic. Now time to deepen and strengthen. Steve Gold’s visionary creation of the Committee on Collaborative Initiatives, chaired by Constance Dalenberg, will be an integral component of this deepening process. Our new fund-raising committee, chaired by Rob Rella, aims to insure that we will grow older as a division with a solid funding base. Given the extremely tight financial situation at APA, where 37 positions were eliminated and 32 staff laid off this past summer, Division 56 needs more than ever to look beyond the mothership for funding support. Steve’s vision has gotten us on this trajectory well ahead of our need becoming acute. Topher Collier and the EC’s decision to make the newsletter mostly electronic (with paper copies for folks who don’t enjoy reading on-screen) is yet another visionary step that will allow our division to move strongly past toddlerhood.

I’ve created two task forces to start during my presidential year of 2010. The first, on Assessment of the Sequelae of Psychological Trauma, will be chaired by Judith Armstrong. She is currently recruiting members, and is tasked with looking at the range of assessments, cognitive, objective, and projective, for children and adults, with both U.S. and international applications. As a psychologist who both does assessments and trains doctoral students in trauma-informed assessment I am thrilled that we have Judith’s talent on board for this project.

My second task force reflects my presidential theme, “Trauma Psychology: Research and Practice Serving Social Justice.” The Task Force on Trauma Psychology and Social Justice will be chaired by Amber Douglas. Amber’s group has been asked to find our best examples of how trauma psychologists’ work moves justice forward in the world, and to develop heuristics that any trauma psychologist can use to advance the creation of a more socially just world.

Mostly, though, I’m hoping to spend my year as president, like a good parent of toddlers, helping us become more stable and grounded, and more skillful in the application of our developing competencies as a division. I’ve been the fortunate recipient of much training in how to run divisions well from my colleagues in 44 and 35 (of which I was president in 1996–1997. Notice a pattern: one division every decade or so; although I have promised my partner that this is really, truly, the last one). To accomplish my goal I will need your assistance: your ideas, your constructive feedback about what we could do better or more of, and your active participation. A division is, after all, much more than its leadership; it’s the collective energies and visions of the community of the whole. We in the field of trauma psychology know that what we do is urgent and sadly necessary. With all of your help we’ll get this toddler ready for the next stage. Thanks again (I think) for your confidence in me.

Winter 2010 Issue of TPN

The Trauma Psychology Newsletter is accepting articles for the Winter 2010 issue. The deadline for submissions is December 15, 2009. 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. Please also include a brief author bio and photograph (jpg or tiff formats only).
Domestic abuse is now a term common to those attuned to the social media. Women and children escaping violence in the home often make their way to Battered Women’s Shelter’s for treatment and safety. In this environment, they are offered counseling that allows them to heal and gain independence from their abusers. Long term abuse can result in posttraumatic stress disorder (PTSD); while there has been much research surrounding treatment methodologies for PTSD, there has been little qualitative research giving voice to the victims themselves. There is a void of qualitative information to guide the clinician in providing the type of counseling relationship specifically needed by women in intimate partner violent relationships (Bograd, 1994; Stainbrook & Hornik, 2006). The voice of the victim is missing in research; questions such as how the clients perceive counseling and what they believe they need from counseling are lacking (Bassuk, & Huntington, 2006; Bograd, 1994; Brosi & Carolan, 2006) Additionally, existing research focuses on clients of homeless shelters rather than domestic violence shelters (Stainbrook & Hornik, 2006). A recent qualitative study aimed to provide information that was lacking in prior research. This study gave voice to the women seeking counseling for domestic abuse; they were asked to express what they felt they needed from the therapist. The project of this researcher focused entirely on women who sought assistance from a domestic violence shelter.

Conversational interviews with the participants were hermeneutic. Dialogues were oriented towards giving experiential meaning to the topic under discussion. Researcher and participants reflected on traumatic experiences and used that reflection to discover personal meaning. Words became data that was analyzed for themes, patterns, or recurrent images. The analysis focused on one core question, “What do women living with abuse need from counseling?”

Transcript analysis showed a recurrent theme of needing validation from an external source. Experientially, all women mentioned a need for validation in all senses and areas of perception, facts, decisions, everything pertaining to their past years of abuse and the ensuing healing process for trauma. They were beautifully articulate in describing the ugly moments in their past, and expressing what they needed from the therapist in the area of validation.

Existing literature of experts had identified an external locus of control existing in women who stayed in battering relationships (Harway & Hansen, 2004) They point out that women who tend to remain in battering relationships have a more external locus of control than do women who left the battering relationship or never entered into a battering relationship to begin with. Locus of control is central to several corresponding pieces of literature pertaining to culture and religion.

World view has an impact on an individual’s thoughts and meaning making in situations and can best be understood in qualitative studies of individuals (Sue, et al., 2002). Herein lays the value of a qualitative study that focuses on the voice of those seeking counsel for domestic abuse. Gender roles and culture are enmeshed; they influence one another in a circular fashion (Unger & Crawford, 1996). Gender roles are strongly affected by religious beliefs and religious community. The relationship between gender and religious culture is mediated by religious and gender beliefs within family systems. Gender in society can also represent cultural roles in religion that are not sufficiently addressed in counseling (American Counseling Association, 2003; Bograd, 1999).

There are barriers experienced by fundamentalist protestant Christians (FPC) in counseling for domestic violence. Counselors who treat victims of domestic violence may see specific religious beliefs as unhelpful or irrelevant to treating the victim of domestic violence (Johnson & Ferraro, 2000). Cultural vulnerability exists for those from Latin American culture that contains gender role archetypes that play a role in perpetuating violence within the family, and within the culture (Gomez, 2007). Indeed, in many cultures violence against women is justified when women do not follow traditional gender roles and norms (Heise & Ellsberg, 2001).

These cultural barriers explain why validation may have been the most salient need expressed by women seeking DV counseling. Following are some of the excerpts from this qualitative study revolving around validation. Participants chose pseudonyms for the study.

Althea is a 48-year-old Caucasian female with Bachelors in English. She survived 12 years of domestic abuse. She and her abuser had attended couples counseling. He dropped out after three sessions.

The counselor pointing out emotional abuse to me was an important event. If you listen to your spouse, you are the only one with the problem. To have someone tell me, “yes, that is abuse, your spouse is the one with the problem,” that validation was very important to me. The habit in my family was to gloss things over. To say something negative in my family carries a risk. I’ve been seeing the counselor ever since.

Ariana is a 38-year-old Hispanic with Bachelors in Marketing. Her abuse is unique in that the physical attacks came every two or three years.

I began attending women’s groups at a local shelter. The group helped me to realize and accept my abuse. The group provided validation that the treatment I was experiencing in my marriage was not right. I have a sister who is mentally ill, so my family views counseling as
Counseling Victims of IPV

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being for those who are crazy. Group counseling gave me knowledge and validation to seek individual counsel for my experiences. I thought my situation was unique. The counselor showed me that though we are unique, we often face similar familial patterns that lead to abusive relationships. She helped me to say, “OK, I am normal.” Now I help other women I meet to identify their own patterns.

Nancy is a 46-year-old Caucasian with the dual diagnosis of bipolar.

I was a well paid chemist from an affluent background. I have less money now than I have ever had in my life. My husband’s verbal abuse left me feeling worthless over the years. Through counseling, I was finally able to leave him. He threatened me, pointed a gun in my face, and stalked me at work causing me to lose the job. I came into counseling needing all kinds of self-esteem work. We as women are raised to nurture others and often do this at our own expense. The counselor was good about showing me that I did not deserve what was going on and that I was entitled for it to stop.

Paloma is a 48-year-old Caucasian woman whose family history led her to need validation from an external source.

She has been married for 20 years to her abuser.

In my marriage, I have experienced domestic violence. In our house there was a double standard. My brothers all got degrees and the girls were told to settle down and do house work. Love in our family was conditional. There was a male relative who molested us girls. Mother did not want us children to tell what was happening to us. In a seminar, I heard a speaker talking about Domestic Abuse. I saw that all of the symptoms were in my life. My husband used to force me to do things I did not want to do. I entered counseling. Once I realized I did not have to do things I did not want to do, I was able to resist his manipulation games of, “you’re my wife, you need to take care of me, etc.” Now we live separately. I have time for myself now. In counseling somebody is listening to me and believing in my feelings saying they are real. This validation was a life line.

Therese is 55-year-old Caucasian with a history of domestic violence and sexual assault. She is a trained nurse.

My father was an alcoholic; physical and emotional abuse was common in our home. The abuse was a family secret. The abuse in my marriage triggered my childhood abuse. I entered counseling. My husband was shaking me and shouting at me. I went into a dissociated state, just blocked out everything he said; I could not move or cry for help. My husband was in the military. He would say he was returning from a mission on a certain day, and then would show up days later without calling. Counseling showed me that this behavior was unacceptable emotional abuse. The counselor helped me to know what is real, normal and right. In children from alcoholic or abusive families, reality becomes blurred. I could not discern what was real or false. Therapy helped me to make wiser decisions.

Other participants voiced similar need for validation in the context of their unique social and cultural history. Personal narratives studded with gems of experience in story form are one of the best formats for understanding the storyteller’s identity across the life span (Clandinin, 2007). In each woman’s story this researcher noticed “gems” that led to patterns of the need for external validation. The qualitative nature of the study brings clarity to the role of gender role stereotypes in society and religion. These insights can assist therapists in addressing the experiences of trauma in a domestic setting and understanding the nature of validation unique to each survivor. The full text of this research is available through PsycINFO.

References


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Save the Date!

APA 118th Annual Conference
August 12–15, 2010
San Diego, California

Museum of Man San Diego
Trauma-Informed Care: Trauma as an Organizing Principle in the Provision of Mental Health and Social Services

Editor’s Note: This article was invited submission by the Division 56 Science Committee, chaired by Dr. Jennifer Freyd, and on which Dr. Lisa Butler is an active member.

Lisa D. Butler, PhD, and Molly R. Wolf, LMSW
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The increasing awareness over the past two decades of the prevalence of traumatic experiences, especially those suffered in childhood, has kindled a dawning recognition of the implications of trauma for the provision of mental health and other social services. This recognition, in turn, has coalesced into a new perspective on service delivery: the need for services that are “trauma-informed.”

The term trauma-informed most commonly refers to client care that takes into account the potential role of violence and victimization in the lives and development of individuals using social services, including mental health (Harris & Fallot, 2001). This client care involves the recognition of the staggering prevalence of traumatic experiences in the histories of those served by social service providers, as well as an understanding of the psychobiological sequelae of such experiences and their impact on the problems seen in service settings (reviewed in Jennings, 2004a, 2004b). Trauma-informed care is distinguished from trauma-specific assessments and interventions that are designed expressly to identify and address the symptoms and conditions associated with past traumatic life experiences. As Harris and Fallot (2001; Fallot & Harris, 2008) have noted, “Trauma-informed services are not designed to treat symptoms or syndromes related to sexual or physical abuse. Rather, regardless of their primary mission—to deliver mental health or addictions services or provide housing supports or employment counseling, for example—their commitment is to provide services in a manner that is welcoming and appropriate to the special needs of trauma survivors” (p. 5).

In the following, we describe some of the factors that contributed to the development of the trauma-informed care perspective, its growing movement, and some of the preliminary empirical support for the construct.

The Development of the Trauma-Informed Care Perspective

The impetus for the development of trauma-informed care came in part from the increasing recognition of the high prevalence of traumatic events in the lives of people generally, and particularly of those seeking public health, mental health, and social services (e.g., Ko et al., 2008; Mueser et al., 1998; Pecora, White, Jackson, & Wiggins, 2009; Salasin, 2005).

The Adverse Childhood Events (ACE) Study (www.acestudy.org), a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente in San Diego, provided convincing early evidence. This ongoing investigation uses data from a large sample of HMO enrollees to examine the relationships of childhood trauma and household dysfunction to health and behavioral outcomes in adulthood. Its first report, published in 1998, bore the sorry news that adverse life events in childhood were far more prevalent than previously understood. More than half of this adult sample reported at least one adverse experience of childhood abuse, neglect, or growing up in a dysfunctional home (Felitti et al., 1998), with many reporting two or more ACEs.

Those served by social service agencies report even higher rates. For example, studies (as reviewed in Jennings, 2004a, 2004b; see also Goodman, Rosenberg, Mueser, & Drake, 1997; Mueser et al., 1998) have found that physical and sexual abuse histories are vastly overrepresented among both teenagers and adults with alcohol and drug problems, including those with dual diagnoses. More than four in five adolescents and children in one intensive residential treatment program sample reported trauma histories. Among incarcerated females, more than 80% had been victimized in childhood. More than 40% of women receiving public assistance were sexually abused as children. Between 51–98% of public mental health clients have experienced a traumatic event, with most having multiple exposures. Similarly, virtually all of a sample of mentally ill homeless women had histories of severe sexual and/or physical abuse.

The effects of trauma on children can be far-reaching and long-standing (reviewed in Jennings, 2004a, 2004b; see also Felitti et al., 1998; Ko et al., 2008) and may bring survivors—directly or indirectly—to the attention of child welfare and juvenile justice systems or other social service systems serving youth. Similarly, adults abused as children or as adults are also at increased risk of psychosocial and physical health problems that increase the likelihood of involvement with social service agencies and the criminal justice system. Left untreated traumatic event exposure and PTSD are associated with a range of negative psychosocial outcomes (e.g., homelessness, unemployment, prostitution, family conflict, revictimization), health problems (e.g., heart disease, cancer, HIV-positive status, substance abuse and dependence, obesity, and depression), and increased health care utilization in adulthood. Indeed, individuals with trauma histories are thought to represent the largest constituency of consumers of expensive inpatient, crisis, or residential services because of their persistent and debilitating mental health and/or substance abuse conditions.

These findings and others have led some experts to conclude that virtually all users of services in the public mental

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health and substance abuse systems bear histories of trauma (Jennings, 2004a). Nonetheless, even when service agencies recognize that a traumatic event is the circumstance that brings individuals to the attention of the system, it is rare that clients’ trauma histories are explored or conceptualized as formative experiences contributing to their presenting problems; nor is addressing such histories viewed as critical to successful treatment in many mental health settings (Frueh et al., 2002; Jennings, 2004a; Ko et al., 2008). Indeed, most of these individuals are never screened, assessed, or treated for their trauma experiences. As Harris and Fallot (2001) noted almost a decade ago, “Systems serve survivors of childhood trauma without treating them for the consequences of that trauma; more significant, systems serve individuals without even being aware of the trauma that occurred” (p. 3). Additionally, many mental health systems employ coercive and punitive treatments, such as restraint, seclusion, and forced medication that have the potential to re-traumatize clients with trauma histories (Cusack, Frueh, Hiers, Suffoletta-Maierle, & Bennett, 2003).

Other decisive contributions to the development and dissemination of the trauma-informed perspective (described in detail in Jennings, 2004a) include the leadership of the Substance and Mental Health Services Administration (SAMHSA) in sponsoring the “Dare To Vision” conference in 1994 that highlighted trauma, violence, women’s issues, and gender-specific treatment; initiating a large 5-year multi-site study—the Women, Co-Occurring Disorders and Violence Study—in 1998; and founding the National Child Traumatic Stress Network in 2001 (www.nctsn.org), among other independent efforts. As well, in 2001 Maxine Harris and Roger Fallot published their seminal book, Using Trauma Theory to Design Service Systems, where they defined the concept of trauma-informed care and described its applications across a range of service settings (see also Fallot & Harris, 2008).

During the same period, the National Association of State Mental Health Program Directors (NASMHPD) unanimously passed a position paper recognizing trauma as “pervasive, highly disabling and largely ignored” and launched a major initiative to reduce the practice of seclusion and restraint in mental health settings. The NASMHPD also pledged their support for the “implementation of trauma-informed systems and trauma-specific services in our national mental health systems and settings,” and established criteria for trauma-informed mental health service systems that a number of states have implemented or are endeavoring to implement (NASMHPD, 1999, 2004, 2005; cited in Blanch, 2005; Jennings, 2004a).

Furthermore, there was a needed critical buy-in by mental health consumers and some providers, who had recognized for some time that there was an urgent need for improvements in mental health education and service delivery (A. Jennings, personal communication, July 17, 2009). As Bassman (2001) observed at the time, “The consumer/survivor/ex-patient dissatisfaction with the existing mental health system is not a denial of the need for help, but rather a criticism of what is passing for help” (p. 22).

On a parallel track, in 2003 the President’s New Freedom Commission on Mental Health published its final report, Achieving the Promise: Transforming Mental Health Care in America, calling for a fundamental transformation in the country’s approach to mental health care. The proposal emphasized the transformation of service systems and recovery for all individuals served by them (Blanch, 2005). The Commission noted that the achievement of excellent mental health care in the United States would require the development of the knowledge base in several understudied areas, among them, the impact of trauma (New Freedom Commission on Mental Health, 2003). To this end, the Commission recommended that the Department of Health and Human Services, through the National Institutes of Health, embark on a sustained program of research on the impact of trauma on the mental health of specific at-risk populations, such as children, women, and the victims of violent crime.

This convergence of factors—accumulating trauma prevalence data, evolving conceptual frameworks, consumer demand and support, and institutional leadership and innovation—catalyzed a recognition of the need for a fundamental change in service delivery: that it become trauma-informed.

The Elements of Trauma-Informed Care

To provide trauma-informed care represents a profound shift in both perspective and practice, particularly in the context of social service delivery.

A trauma-informed organizational or service system environment is characterized by:

Safety from physical harm or re-traumatization; an understanding of clients and their symptoms in the context of their life experiences and personal history, cultures, and their society; open and genuine collaboration between provider and consumer at all phases of the service delivery; an emphasis on skill building and acquisition rather than symptom management; an understanding of the symptoms as attempts to cope; a view of trauma as a defining and organizing experience that forms the core of an individual’s identity rather than a single discrete event; and a focus on what happened to the person rather than what is wrong with the person. (Jennings, 2004a, p. 15; see also Harris & Fallot, 2001; Saakvitne, Gamble, Pearlman, & Tabor Lev, 2000)

As Elliott and colleagues (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005) put it: “To provide trauma-informed services, all staff of an organization, from the receptionist to the direct care workers to the board of directors, must understand how violence impacts the lives of the people being served, so that every interaction is consistent with the recovery process and reduces the possibility of retraumatization” (p. 462).

Echoing the same sentiments, and building upon the work of Harris and Fallot (2001), the trauma committee of the Women, Co-Occurring Disorders and Violence Study (WCDVS), reached a consensus description regarding ten general principles of trauma-informed services (Elliott et al., 2005). These principles are: (1) recognizing the impact of violence and victimization on development and coping strategies; (2) identifying recovery from trauma as a primary goal in treatment; (3) employing an empowerment model; (4) striving to maximize clients’ choices and control over his or her recovery; (5) basing services in a relational collaboration; (6)
creating an atmosphere that is respectful of survivors' needs for safety, respect, and acceptance; (7) emphasizing strengths and highlighting adaptations over symptoms and resilience over pathology; (8) maintaining the goal of minimizing the possibilities for re-traumatization; (9) striving to be culturally competent and to understand all persons in the context of his or her life experiences and cultural background; and (10) soliciting consumer input and involving consumers in designing and evaluating services.

Research Related to Trauma-Informed Care

Although there is a tremendously compelling and deeply humane logic to the implementation of trauma-informed care in all service settings, this view is relatively recent and empirical support for its implementation is only beginning to accrue. As well, trauma-informed care often includes trauma-specific treatments, thus confounding the possibility of isolating the impact of the integration of a trauma-informed perspective into service delivery from the effects of trauma-targeted treatments. Indeed, the realities of implementing such service provision changes may preclude study designs that dismantle these elements.

The 5-year WCDVS is a case in point. This study was launched to generate empirically-based knowledge on how services could be enhanced for women trauma survivors with co-occurring mental health and substance use disorders. This quasi-experimental, longitudinal investigation was conducted at nine intervention sites across the U.S., with all participating sites agreeing to provide services that were: (1) integrated in providing services for treatment of trauma, mental illness, and substance use, (2) trauma-informed, (3) consumer-involved, and (4) comprehensive. Sites differed by primary focus (i.e., substance abuse, mental health, or community-based), setting (i.e., inpatient, outpatient, or mixed), and the trauma-specific interventions that were implemented (Elliott et al., 2005; Morrissey et al., 2005), though all sites did provide these latter services. Each intervention site also chose one or more comparison sites that provided care-as-usual services to similar clients in the same region.

Findings from the WCDVS research overall indicate improvements at 12 months in both posttraumatic stress and mental health symptoms for women receiving the interventions compared to controls, although no differences between conditions were found for physical health (in this case both groups improved; Weissbecker & Clark, 2007) or substance use outcomes (Morrissey et al., 2005). Of note, one site did report positive effects on substance use behavior; Gatz et al., 2007. Additional findings from a subset of sites indicate that the intervention was also associated with better client retention, lower rates of unprotected sex, and improvements in dissociative symptoms, trauma coping, and sense of safety (Amaro, Chernoff, Broan, Arévalo, & Gatz, 2007; Amaro, Larson, et al., 2007; Toussaint, VanDeMark, Bornemann, & Graeber, 2007), when compared to treatment-as-usual. Additionally, a trauma-informed intervention for children of the parents in this sample yielded improvement on emotional and behavioral outcomes for these children (Noether et al., 2007). Overall, this study provides consistent support for an integrated, trauma-enhanced approach over standard care.

Trauma-informed care is also the essence of the groundbreaking Sanctuary Model developed by Bloom (1997, 2003). The Sanctuary Model is a comprehensive approach to treatment that addresses issues of trauma and chronically stressful conditions by changing organizational culture so that the system is not only safe for clients, but also for staff and administrators. As Rivard (2004) has noted, “the treatment environment is a core modality for modeling healthy relationships among interdependent community members” (p. 3). Bloom’s model, originally developed for adults with histories of childhood trauma treated in short-term, acute inpatient psychiatric settings, has since been adapted for other settings, including residential treatment for children, domestic violence shelters, group homes, outpatient settings, substance abuse programs, and parenting support programs, among others (for more information see: www.sanctuaryweb.com), although published findings have been limited to date (for some initial findings, see Rivard, Bloom, McCorkle, & Abramovitz, 2005; Wright, Woo, Muller, Fernandes, & Krafcheck, 2003).

The incorporation of trauma-informed principles and practices, in some cases augmented with trauma-specific interventions, has also been found to be beneficial in other settings as well, including programs for delinquent children and adolescents in court settings (Howard & Tener, 2008), peer support for those accessing mental health services (MacNeil & Mead, 2005), psychoeducational groups for parents (Huntington, Moses, & Veysey, 2005), and interventions for homeless mothers (Tischler, Edwards, & Vostanis, 2009). However, many of these reports did not include rigorous evaluations of outcomes.

Additionally, there have been efforts aimed at reducing coercive procedures in mental health settings to make treatment more humane and diminish the possibility of retraumatization for those with trauma histories. The emphasis on avoiding re-traumatization is critical because psychiatric settings can be particularly frightening when hospitalizations involve events, such as involuntary admission, seclusion, forced medication, physical restraints, exposure to frightening or very sick patients, and being handcuffed by police, each of which has the potential to trigger associations to past abuse experiences. Indeed, those with histories of sexual or physical abuse tend to be the most severely distressed by these procedures (Cusack et al., 2003).

One initiative launched by the Massachusetts Department of Mental Health (DMH: LeBel et al., 2004) was precipitated, in part, by findings that the use of restraint and seclusion (R/S) practices in that state were five to six times higher for children and adolescents than for adults. This information, coupled with growing national unease about such practices as well as mounting knowledge of the trauma history rates among these youth (e.g., Lipschitz, Winegal, Hartnick, Foote, & Southwick, 1999), prompted the development and implementation of statewide R/S reduction strategy that included an articulation of the goal to reduce or eliminate R/S practices statewide; a charge to all licensed or contracted facilities/units to develop a R/S reduction strategic plan; considerable clinical consultation, training, and technical assistance provided by the DMH; and ongoing

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use of quantitative, facility/unit-specific data monitoring and feedback. This statewide effort paid off. Comparing parallel 3-month periods before and after the interventions, there were substantial reductions in total R/S episodes (per 1000 patient days) and hours: episodes decreased by 66% in child units and 38% in adolescent units, with hours per episode decreasing by 31% for adolescents and 19% for children. Notably, and contrary to original concerns, the use of involuntary medication also decreased markedly. Other programs (e.g., Walsh, 2002, as cited in LeBel et al., 2004) have reported comparable or better results for adults in other mental health systems.

Conclusions
In short, the findings to date are promising, both with respect to implementing trauma-informed program changes, as well as to the benefits of trauma-informed, integrated interventions. It is worth bearing in mind, though, that trauma-informed care is not a treatment per se, but rather it represents a shift in orientation regarding the backdrop for treatment and service delivery. Trauma-informed care offers a new and compelling organizing principle for viewing the problems and challenges facing those receiving social and other services, as well as a context to inform, and perhaps transform, the outlook of those providing those services. To repeat and paraphrase Jennings and others (Harris & Fallot, 2001; Jennings, 2004a; Saakvitne et al., 2000): to ask, “What happened to you?” rather than “What’s wrong with you?” Some proponents have even described the trauma-informed perspective as a paradigm shift (e.g., Harris & Fallot, 2001). We can hope.

References


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**River of Hope: A Haven of Help in a Storm Devastated Ninth Ward**

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It is a blistering hot 99 °F spring day, in the Ninth Ward of New Orleans, but it feels more like the middle of summer. The tents have been set up, the tables laid out with a variety of paper goods, red beans and rice, and red velvet cake. Children frolic on the green lawn, cold juices boxes held tightly in their sweaty hands. Soon the drummers arrive in tandem; and gather themselves and their instruments in a circle. Slowly a crowd of local residents congregate for the monthly healing drum circle organized by the River of Hope project at the Walk-in Mental Health Center located in the New Salem Baptist Church.

Traditionally a drum circle is a community music-making event where people sit or stand in a circle while playing hand drums and percussion instruments; participants range from a handful of experienced players to circles with people drumming for the first time; the primary purpose is to provide opportunities for people to come together and communicate through the drum beats. Drumming usually consists of improvised rhythms and the music is thus created in the moment. In the drum circle, there is no audience and everyone participates according to their comfort level by clapping their hands, stomping their feet or nodding their heads.

According to psychotherapist Robert Lawrence Friedman (2000), author of *The Healing Power of the Drum*, drumming is innate to the human condition and resonates with the inner rhythms of our heartbeats, breathing, and brainwaves. Drumming has several benefits; it provides both the seasoned drummer and the neonate, with a positive experience and brings people of all ages, abilities, races and cultural groups together. Drumming is a universal language that everyone understands; we can all differentiate between somber beats and more spirited ones.

As an expressive activity, drumming supports the control and release of emotions and stress. Drumming has holistic dimensions: it is a physical activity that involves coordination of the body and mind, and provides good exercise. Further, it has cognitive elements that include perception, attention, and memory. Therapeutically drumming is a communication tool connecting drummers in a group setting; even those who observe the drumming are drawn into the spirit of shared purpose.

Finally, the drum is a powerful instrument and those who drum often feel the power of the instrument in their
hands; this feeling of empowerment transfers to both the player and the listener. For the residents in the Ninth Ward the monthly drumming circle provides an opportunity to express the pain and losses that Hurricane Katrina wreaked upon their community, it acknowledges the hardship and suffering they have borne since that fateful day of August 29, 2005. For a brief moment, at least, they are able to release some of their stress and the storm does not retain mastery of their lives. The drum circle was conceived as a monthly event at the Walk-in Mental Health Resource Center to bring community members together, and make the center a familiar and comfortable place; thus reducing the stigma usually attached to seeking mental health support.

River of Hope is the inspiration of Dr. Rebecca Thomley, a psychologist and CEO of Orion Associates, a Human Services Management Company based in Minneapolis, Minnesota. After a Red Cross deployment in the aftermath of Hurricane Katrina, like many first responders, she found the images of human anguish, pain and suffering unshakeable. Dr. Thomley was determined to return to the storm devastated Gulf coast in order to help survivors re-establish their former lives. She proposed the idea of a hurricane recovery trip to her staff at Orion Associates; they enthusiastically supported the philanthropic idea and thirty-five people immediately signed up for the first volunteer activity scheduled for Thanksgiving weekend (2005) in New Orleans.

During her deployment Dr. Thomley had established a relationship with Pastor Warren Jones whose church and church community in the Ninth Ward of New Orleans was ravaged by the storm. She had promised him that she would return to assist in restoring his flooded neighborhood; she made good on this promise. Twenty-two days after the volunteer project was first proposed, a large truck filled with donated cleaning supplies, personal items, clothing, food and building materials left Minnesota for New Orleans. The rest of the volunteers boarded planes to join them in the Gulf Coast. Travel and accommodation expenses were covered by fund raising and other private donations.

On the afternoon of November 26, 2005, the first group of 35 volunteers arrived at the New Salem Baptist Church of Pastor Jones. The volunteers planned to spend several days helping residents make their homes livable again; they anticipated spending the weekend doing heavy-duty housecleaning and were armed with large supplies of bleach and mops to ensure that this task was accomplished. They met a different reality. Flooding had left behind a slimy residue that clung stubbornly to everything it had touched; mold appeared to be growing profusely; and the stench was overwhelming. Cleaning alone was not sufficient in restoring the neighborhood; most of the homes needed to be completely stripped and gutted. Undaunted, the eager volunteers devoted themselves to accomplish this challenging task.

They worked, side by side with area residents who shared stories of evacuation, escaping flood waters, survivorship and loss. They were trauma stories that left an indelible mark on the listeners. It soon became apparent that this first trip would be one of many and thus was born the River of Hope volunteer project. Multiple trips to the Gulf Coast soon followed. Since rebuilding was identified as a clear need by the community, people from building and construction trades were recruited as volunteers. River of Hope quickly evolved into a statewide and national volunteer effort.

Twelve similar relief trips to New Orleans’ Ninth Ward involving more than 460 volunteers from Minnesota, employed in a variety of occupations (construction workers, plumers, electricians, roofers, etc.) were organized. Volunteers raised and distributed thousands of dollars worth of supplies and contributions and provided over 12,000 hours of labor. During the first three years following Hurricane Katrina, River of Hope volunteers gutted over 50 homes, remodeled the homes of five elderly individuals, and rebuilt six community structures including a church, a domestic abuse center, a mental health resource center and two homes that serve elderly individuals.

A major accomplishment of River of Hope was the development of the first Walk-in Mental Health Resource Center in the Ninth Ward. The resource center first opened in January 2007, funded mainly by private donations. However two years later, in January 2009, the resource center obtained funding through a grant from the Louisiana Department of Health and Hospitals. The River of Hope Mental Health Resource Center uses volunteers to provide counseling, resources, referrals and community education.

Volunteerism inevitably transforms everyone it touches and there is little doubt that individuals benefit from doing volunteer work that extends far beyond the volunteer act itself; the benefits linger long after the volunteer role ends. However, these benefits are usually unintended consequences of philanthropic actions that are intrinsically motivated. Indeed, for many volunteers, volunteering is an expression of values they hold sacred and which are embedded in the act itself, attaching rewards to altruistic behavior can be perceived as undermining their motivation and distorting their values.

Participation in the River of Hope project resulted in several changes at a personal, interpersonal and institutional level for both volunteers and staff of Orion Associates. At a personal level, the roles that some volunteers were assigned led to professional transformation. For example, staff members from Orion Associates were often placed in team leadership positions during the volunteer trips; and company...
management was often part of these teams. As volunteers, they demonstrated a tremendous growth in leadership skills; they confidently stepped into their roles, quickly developed superb organizational skills, appeared to exercise good judgment and displayed a capacity to efficiently guide and support their teams. These skills were later put to good use in their work at Orion Associates.

Second, volunteers had multiple opportunities for cross cultural interaction and engagement; it was an experience that could not be replicated in any diversity training curriculum. The experience of working in the Ninth Ward’s poor, mostly black neighborhood was a transformative experience that increased their sensitivity to working with those who were culturally different. Through practical experience, they gained great understanding of how race, class and culture in America intersect. These personal gains had lifelong benefits.

Third, a commitment to service evolved among River of Hope volunteers who were inspired to become active change agents in their own communities when they returned to Minnesota. For example, they became enthusiastic supporters of local volunteer activities and reported enlisting in several ongoing volunteer activities; some participated in breast cancer fundraising and hand packaging food for the hungry while others engaged in raising awareness and taking action in response to the genocide in Darfur.

On an interpersonal level, the volunteering improved relationships, increased camaraderie and a sense of trust both among staff members and between staff and management of Orion Associates. Working together in the service of others connected people in indescribable ways; the shared experience of helping was taken back to Minnesota and translated into improved collaboration and co-operation in the workplace. Lasting friendships, both personal and professional developed during the volunteer engagement.

The volunteer activities also resulted in institutional changes and River of Hope strengthened the home organization’s (Orion Associates) commitment to contributing to the community. The unique approach to relief recovery that the organization had developed was viewed positively and a decision was made to make crisis response an integral part of ongoing initiatives. This resulted in a new non-profit corporation, Headwaters, LLC within the existing institution. The mission of the new corporation was to react with agility and compassion when disaster strikes; and to provide practical aid, physical recovery assistance and mental health support to victims after first responders have come and gone. In 2007 the new corporation had its first opportunity to respond when severe floods struck Minnesota that summer; within 24 hours a veteran team of River of Hope relief workers were on the road to the communities that were hardest hit by the floods.

It is certainly true that a small act of giving can have untold repercussions. The fulfillment of a promise made to an individual in his moment of crisis was both an act of generosity and compassion with incalculable consequences; the opportunity it has brought and continues to bring cannot be measured. Similarly, long after the sounds of the drum beats have faded the sense of connection, healing and comfort that it instilled remains.

Reference

Priscilla Dass-Brailsford is a faculty member in the department of Psychiatry at Georgetown University. She studies the effects of trauma, specifically community violence and other stressful events and is particularly interested in whether individuals from historically oppressed or stigmatized groups experience unique stressors or exhibit culturally specific coping processes. She is currently working on a project to develop a parenting program to support individuals whose children have been affected by a major disaster. She is also collecting data on mental health workers including school counselors, clinicians, pastors and other professionals working in the Gulf Coast with the goal of assessing secondary trauma among helping professionals who have experienced stress and dislocation after Hurricane Katrina. Dr. Dass-Brailsford has published articles in the areas of trauma, multiculturalism and community psychology. She has two published books: A Practical Approach to Trauma: Empowering Interventions (2007, Sage Publications) and Crisis and Disaster Counseling: Lessons Learned from Hurricane Katrina (2009, Sage Publications). She is an APA Fellow and currently a member of the American Psychological Association’s Committee on Women in Psychology, chair of the Community Engagement Committee for the Society of Counseling Psychology and co-chair of the Multicultural Committee for the Society for Trauma Psychology. In the recent past, she was chair of the Committee on Ethnic Minority Affairs. Dr. Dass-Brailsford has made presentations in trauma to many organizations both nationally and internationally.

Rebecca S. Hage Thomley serves as President and CEO of Orion Associates; Meridian Services, Incorporated; Zenith Services; Orion Intermediary Services Organization and Headwaters Relief Organization. In this position she is responsible for setting vision, strategy and overseeing all aspects of the four organizations. Dr. Thomley holds a degree in Psychology and Criminal Justice; a Master of Science degree in Psychology, with an emphasis in Rehabilitation Counseling; a Master of Arts degree in Organizational Management; and a Doctorate in Clinical Psychology. She is finishing a master’s degree in Psychopharmacology. She is President-Elect of the Minnesota Psychological Association, and the Disaster Relief Network representative for Minnesota. Dr. Thomley is active in the Red Cross and is passionate about environmental concerns, the promotion of volunteerism, and community engagement. In addition to her leadership activities in the Orion agencies, she is a practicing clinical psychologist.
“Smile for Sierra Leone...as they smile for you, despite their tragedy”

Ani Kalayjian, EdD
Founder Association for Trauma Outreach and Prevention

Walking through the streets of Freetown, Bo, Gobaru, & Pujehun in Sierra Leone one witnesses the horrors of the evil war from 1987–2000 which resulted in hundreds of thousands of deaths, houses burned, parks destroyed and enormous damages to the country’s infrastructure. Most importantly, this devastation on the surface does not seem to have destroyed the indomitable human spirit, and the monumental commitment to serve of those who have survived. Meeting and working with Sierra Leoneans, one would quickly feel at ease as their warm smiles, kind hearts, and honest approach is ever present. On first introduction, you would not know what they hold courageously inside. Once one engages more deeply with the survivors, talking with them about their experiences of war, their loss, anger, fear and uncertainty loom large in the silence between each story and in the emotions provoked in the telling. Suppressed anger is rampant, with stories jostling one against the other of senseless mutilations, killings, and atrocities by brother against brother. Thoughts of the future evoke fear and uncertainty. Fearful statements such as “perhaps the war could happen once again, soon” are heard frequently.

Meaningfulworld has organized 25 Meaningfulworld Humanitarian Outreach Projects (MHOP) around the world since 1989, including its first project in 2009, the Association for Trauma Outreach and Prevention (ATOP), organized and implemented by Dr. Kalayjian and the U.S. team. Its goals were to (1) assess psychosocial and spiritual needs of the surviving community, (2) train outreach teams in three towns, (3) conduct collaborative mental health research on levels of distress compared to levels of forgiveness, (4) define and access underlying tensions, and (5) address the needs of the surviving communities in Sierra Leone. More specifically the research goals were to assess levels of distress as compared to the levels of forgiveness.

The first two days were spent assessing the physical and human destruction. The next two days the team was busy giving intense two-day training to the community of faculty and students at the Freetown campus of Njala University. The team traveled next to campuses in Njala and at the Community Health Center in Bo. Then the MHOP team traveled to Gobaru and Pujehun they worked with children, adolescents, and adults using draw-and-tell art therapy techniques, and movement therapy.

As Rev. Dana Marks, MSW, affirms: “The trip to Africa was full of the contrasts of challenge and success. When I think about it deeply, it was and continues to feel like an emotional balancing act, stressful, sad, but full of laughter, hope, empathy, and meaning, combined with compassion, love, patience, personal growth and much more…”

The preliminary findings of the assessments done by the team indicated high levels of posttraumatic stress disorder (70%) in adults and children, and 35% in the local mental health professionals and psychosocial rehabilitators.

The following were themes that were consistently expressed by the survivors: destruction, horror, killing and mutilations. Horrific accounts were expressed one after the other. One survivor’s three siblings were beheaded and their heads delivered on sticks; another survivor’s aunt was publicly crucified and then set on fire; a third woman survivor, who was at the time a 14-year-old adolescent, was raped publicly and repeatedly ridiculed and humiliated; and a fourth survivor was sold to a Nigerian peace-keeping soldier and forced to have children by him, finally managing to escape the horrors several years later. These experiences caused feelings of enormous sadness, grieving, anger, shame, humiliation, frustration, fear, and uncertainty in the survivors.

These expressions of survival further humbled the team and filled them with admiration for the enduring spirit of the people before them. Julie Lira, an art and play therapist put it so well when she reflected, “Africa was beautiful and horrific all at once. I have to say the things that I will treasure the most from my trip are the beautiful people of Sierra Leone, their stories, and seeing their God light through their eyes; I so admire their resilience in spite of all that they suffered and endured.”

Lessons learned were the importance to the survivors of family support, of everyday living, of serving others, of desire and hunger for education, and of forgiving. For individual Meaningfulworld team members, lessons were multiple. According to Julie: “I learned the human spirit is a strong thing that if accessed can guide us all thru a lot of trauma, and I will never forget the poverty, the lack of basic necessities. How in one moment man can do this much harm to another man over greed is abhorrent. But most of all that the power to make changes lies within each one of us.” According to Dana the lessons were of gratitude and appreciation: “We (on this side of the world) do not realize how wonderful it is to have running water, flushing toilets, electricity and paved roads...thank you, thank you, thank you.. We also do not have the pleasure of knowing how beautiful it is to live off the land, growing our own fruits and vegetables as well as catching our dinner.” Dr. Ken Suslak, PhD, expressed these lessons: “Above all, humility, awareness of one’s limitations and strengths in making a difference, the power of forgiveness when accompanied by social justice, the value of compassionate listening to these stories and the need to share them with the world.”

The MHOP team has established the following groups within Sierra Leone (SL): (1) Green Future for SL (Bo branch) to address environmental needs of their communities, such as Plant a Tree Project; (2) a men’s group to encourage expression of feelings and for promoting inner peace; (3)
We express our gratitude to the collaborators in Sierra Leone, including Njala University and its campuses in Freetown and Bo, The Psychosocial Network, and Saving Lives Through Alternate Options (SLAO.org ). The first Meaningfulworld Humanitarian Outreach team comprised Dr. Kalayjian, Dr. Ken Suslak, Rev. Dana Mark, Julie Lira, and Gen Zado-Dennis, the videographer. The team was also joined by Judith Lahai-Momo the Director of SLAO.org, a US based non profit working in that region. The Njala University Chancellor Rhodes stated, “Your arrival and your work in Sierra Leone is very timely, as the signs of violence are still erupting all around us. Your teachings and trainings will be invaluable for us and your continued collaboration in future projects is much needed.”

Future collaborative goals were set forth with Njala University, Meaningfulworld, and Fordham University. This collaboration will start with (1) internships and externships, (2) Fulbright exchanges, (3) telesupervision, (4) collaborative research, (5) collaborative publications, and (6) policy improvements.

Challenges for growth are ever-present as Sierra Leone is dealing with multiple issues since a postwar recovery that began in 2000. Much of the global humanitarian assistance stopped since the war had ended, but the country needs continued guidance and support. Many of the international NGOs have left the country, and little recovery has taken place. Corruption is rampant, poverty continues, infrastructure is very poor, illiteracy very high, lack of basic human needs is shocking; specifically lack of running water, electricity, cooking gas, paved roads, public transportation, just to name a few.

Meaningfulworld has succeeded in its mission by (1) providing opportunity for release of emotions and for awakening; (2) providing empathy and validation; (3) helping survivors recover or discover capacities for self growth, empowerment, and meaning-making; (4) establishing several groups to promote Meaningfulworld’s mission; (5) helping share the value of forgiveness; (6) sponsoring a project for improving the Njala University Library; (7) providing survivors with hope and with the ability to reframe their experiences; (8) providing the surviving community and its local rehabilitators with new and healthier tools for stress reduction through assertiveness, movement, and meditation; (9) providing resources, books, and web links; (10) providing models for cooperation; and (11) sowing seeds of service to the surviving community.

The MHOP team was welcomed home by Vice President of Development, Georgina Galanis who empathically observed: “I did hear the joy reflected in your emails ... the sadness for loss of human value through the devastation of war, the gratitude for what we all have here, and the hope we can all be, when we share as a common human value and aim, ‘To live a good life in love multiplied and shared.’ So happy to hear you have returned safe and blessed... I can’t wait to see you all and hear your stories... sending you all admiration for your commitment realized. I wish you all rest and rejuvenation.”

The team will be disseminating their work locally, nationally, and internationally through publications, research, and DVDs. We invite you to continue to “Smile for Sierra Leone” as the survivors of Sierra Leone smile for you despite their tragic history ... and please don’t hesitate to send your generous donations to be part of the change you want to see. The work has just begun in Sierra Leone, we need to continue it, and we need your unconditional and genuine involvement and support.

Ani Kalayjian, EdD, BCETS, DDL, BCCM. Awarded Honorary Doctor of Science degree from Long Island University (2001) recognizing 20 years as a pioneering clinical researcher, professor, and administrator around the globe and at the United Nations. In 2007 she was awarded Columbia University Teacher College’s Distinguished Alumni of the Year. Author of Disaster and Mass Trauma (1995) and of over 40 articles on clinical methods, human rights, trauma transformation, and women’s issues; editor-in-chief of Mass Disaster & Emotional Healing Around the World: Rituals and Practices for Resilience and Meaning-making (2009, 2 volumes); coeditor of the international book Forgiveness & Reconciliation (2009); Contributed a model for trauma recovery, healing and empowerment: The Biopsychosocial and Spiritual Model.

Changemakers, committed service professionals and laypersons wanting to join upcoming Meaningfulworld Humanitarian Outreach missions in 2009–2010 please register for our 7-month certificate training. Information: kalayjiana@aol.com geocolors@gmail.com Link to site here: meaningfulworld.com

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The future of our Division depends on our dedicated Members.
Traumatic Stress Symptoms in Parents of Premature Infants

Kathleen Kendall-Tackett, PhD, IBCLC

Health crises and life-threatening medical conditions can have a significant impact on patients’ psychological wellbeing. Researchers have documented that traumatic-stress symptoms can occur following events such as myocardial infarction, an ICU stay, or cancer. In some cases, patients who experience these events will meet full criteria for either Acute Stress Disorder or PTSD.

Preterm delivery of infants is another health event that can lead to PTSD for parents. By definition, a birth is preterm if it occurs before 37 weeks gestational age. Low birthweight (LBW) often co-occurs with prematurity and is also related to a number of serious health complications for babies. A baby is designated low birthweight (LBW) if their birthweight is below 1500 grams (5.5 lbs.). As younger and smaller babies are being saved, there are the categories of very low birth (VLBW: <1000 grams) and extremely low birthweight (ELBW: <500 grams). Babies as young as 21 weeks gestation have survived, and were eventually discharged from the neonatal intensive care unit (NICU), but the mortality and morbidity rates for the youngest and smallest infants is still quite high.

A preterm birth can be a life-threatening event for both mother and baby. Even when not life-threatening, preterm birth precipitates a psychological crisis. Women who give birth prematurely must face the reality of an infant who may be sickly or fragile when they themselves are psychologically and physically depleted. The babies may also be born following a history of infertility, difficult pregnancy and/or an emergency delivery.

One mother who experienced this situation, Jan, described her feelings after the birth of her daughter. Her daughter was delivered 6 weeks premature, via emergency cesarean section, after Jan developed eclampsia, a life-threatening complication of pregnancy.

They took her away right after delivery. I never got to hold her, after all that [the difficult pregnancy and delivery]. They brought her back, but my arms were tied to the delivery table. I wish they had released at least one arm. It was really hard…. Leaving the hospital without the baby was really bad. I left early because I didn’t want to leave at 11 am with all the other moms and babies…. I shouldn’t complain because she only had a few preemie problems. Others in the nursery were so sick. But it was very stressful. It was awful to see them putting the feeding tube down her throat, hearing her gagging and crying. It makes me cry now just to think about it.

In some cases, especially with babies who are very sick, mothers may experience anticipatory grieving, and begin to mourn the loss of their infants. In this process, they may distance themselves from their babies in order to prepare themselves for their babies’ eventual death. When babies recover, this process of mourning is interrupted, and mothers have to readjust. There are several factors that can influence parents’ reactions following a preterm delivery. These include the overall severity of their babies’ illness, a history of prior infant loss, and the type of intervention they receive.

The majority of research has been done with mothers. But recent studies that have included fathers have found that they are not immune to traumatic-stress reactions following a preterm delivery. These factors are described below.

Severity of Illness

Severity of illness or degree of prematurity can affect parental mental health. The range of illnesses or problems of premature infants varies tremendously. Some babies are hospitalized for only a few days, while others may be in intensive care for several weeks or months.

A study of 40 parents of babies in the NICU found that 44% of the mothers met full criteria for acute stress disorder, while none of the fathers did (Shaw et al., 2006). Acute stress disorder was also associated with alternations in the parental role, which included not being able to help, hold or care for the infant, protect the infant from pain, or share the infant with other family members.

The subjective appraisal of the seriousness of the illness was more predictive of mothers’ reactions than the objective disease characteristics. Family environment and parental coping style were significantly associated with trauma symptoms. The authors recommended that care providers help with parental feelings of helplessness and inadequacy, even with severely ill infants.

Mandated bed rest during pregnancy can also make mothers feel that their babies are at high risk (Maloni et al., 2002). In a study of 63 women who were admitted to hospitals for antepartum bedrest, dysphoria was related to obstetric risk. Women whose pregnancies had the highest risk scores had the highest levels of dysphoria. Gestational age and health of the baby at birth were significantly correlated with postpartum dysphoria.

Prior Infant Loss

Mothers who have premature babies may also have a history of infertility, miscarriage or fetal loss, and this can also increase their risk for depression, anxiety, and posttraumatic-stress symptoms with subsequent pregnancies (Geller, 2004). Janssen and colleagues (1996) compared 227 women whose babies had died with 213 who gave birth to live babies. After 6 months, women whose babies had died showed greater depression, anxiety, and somatization than women who had given birth to live babies. At 1 year, the mental health symptoms had subsided, and the women who lost babies appeared comparable to those who had not lost babies. However, the authors noted that pregnancy loss is a stressful life event that can lead to a marked deterioration in a woman’s mental state, particularly in the first 6 months.
Hughes, Turton, and Evans (1999) compared women who had had a previous stillbirth with a group of matched controls ($N = 82$). Women who had a stillbirth had more depression and anxiety in their third trimesters of a subsequent pregnancy, and more depression postpartum. The results were strongest for women who were most recently bereaved. Not surprisingly, depression during pregnancy was highly predictive of postpartum depression. In the year following delivery, 8% of the control group and 19% of the bereaved women were depressed.

Mothers and fathers can also have traumatic-stress symptoms during an ultrasound for a current pregnancy following a previous perinatal loss (O’Leary, 2005). They may experience the ultrasound as a harbinger for more bad news rather than as a reassuring diagnostic test. A descriptive phenomenologic study of 12 mothers and 9 fathers explored their experiences of ultrasound. All had lost babies in the previous year. Most of the parents indicated that the current ultrasound reminded them of when they had seen their babies die on the previous ultrasound. Many aspects of the experience reminded them of that event: the smells, sights, feelings and sounds of the ultrasound room. During the ultrasound, some mothers experienced flashbacks to when they lost their previous babies—even when the current baby was healthy. Both the fathers and the mothers showed equal levels of trauma symptoms following the ultrasound. Based on her research, O’Leary (2005) recommended recognizing that parents may be remembering their previous babies when undergoing testing for a current pregnancy. She also recommended preparing parents for possible flashbacks during ultrasound, and letting them hear the heartbeat first before the ultrasound, so that they realize that their current babies are very much alive. She also suggested recognizing that fathers may be as traumatized as the mothers and may also need support.

In a review of 17 studies, Badenhorst et al. (2006) also found that fathers were affected by prior loss. They experienced classic grief symptoms, but less guilt than mothers. Fathers also experienced anxiety and depression, but lower levels than mothers. They may also develop PTSD. The authors concluded that fathers may also be traumatized by stillbirth or neonatal death and may need help themselves before they can support their partners.

A study from Germany examined mothers’ feelings of grief after a pregnancy termination for fetal anomalies (Kersting et al., 2005). This study compared the reactions of 83 women who had undergone a termination 2 to 7 years previously, 60 mothers who had undergone a termination 14 days prior, and 65 women who had had full-term babies. Contrary to their expectations, they found that there was no difference in traumatic-stress symptoms between the two groups who had a termination. Both groups differed significantly from the mothers who had healthy full-term babies, and were significantly higher on all three subscales of the Impact of Events Scale. The events experienced as traumatic were the invasive medical procedures, the wait for labor pains to begin, and the delivery of a dead fetus. The authors noted that mothers experienced intense grief reactions in addition to trauma symptoms. They concluded that these terminations had been emotionally traumatic events that led to severe posttraumatic-stress responses that persisted for years.

Reproductive loss or preterm delivery can be life-threatening for mothers as well. Van Pampus and colleagues (2004) described three case studies where mothers developed trauma symptoms after their experience with HELLP syndrome. HELLP syndrome is a serious form of preeclampsia that includes hemolysis, low platelets and liver damage. HELLP syndrome is a potential cause of mother and infant mortality and morbidity. Even several years after the event, the women described themselves as highly fearful and they did not want to become pregnant again for fear of what might happen. They noted that women who experienced HELLP syndrome may suffer from significant emotional sequelae and should therefore be monitored so that they might receive intervention.

Health care providers can provide support for mothers in the wake of infant loss, and this support can ease grief and perhaps prevent trauma symptoms. In a study of women in Sweden who had given birth to live or still born babies, 314 had had a stillborn baby (Radestad et al., 1996). Among these women, 80% had caressed their babies, 90% reported that the medical staff showed respect, and almost 70% reported that the hospital had good routines to support mothers of still born children. However, there was room for improvement. Thirty-seven percent reported that they had been deeply hurt or angered by the behavior of the medical staff. When pictures of their babies were taken, 70% of mothers indicated that they were very or quite satisfied. But about 16% were not at all satisfied, and much had to do with the lack of care taken when the photo was taken (e.g., the baby was placed on the floor for the photo, or the baby was covered with blood). Twenty-one percent had no token of remembrance of their babies.

### Interventions

#### Kangaroo Care

One technique that can be useful for mothers of premature or ill infants is Kangaroo Care. Kangaroo Care involves placing the baby, wearing only a diaper, between the mother’s breasts or on one breast, under her clothing for extended skin-to-skin contact. The babies are held in a sling or pouch. Fathers can also do Kangaroo Care. The benefits for babies appear almost immediately. The babies are calmer and their body temperature stabilizes. They cry less, thereby conserving precious calories. The babies do better physically, and are discharged from the hospital earlier. Mothers also benefit. They feel more confident in caring for their babies, and are more likely to form secure attachments.

As an intervention, Kangaroo Care has a fascinating history. It’s something we never would have tried in the U.S. if it had not been tried first under the extreme conditions of countries in the developing world. Kangaroo Care was started by two Columbian neonatalogists in Bogota. They were faced with a dire situation: namely, a 70% mortality rate for preterm infants. They had no isolates for these babies. Hospital temperatures were often 50° or cooler due to irregular electrical service. In order to address these issues,
these physicians tried keeping mothers and babies together, with skin-to-skin contact. They soon learned that Kangaroo Care was good for both—and it cut the mortality rate in half.

In a study in India, Parmar and colleagues (2009) studied families of 135 babies with an average birth weight of 1460 gm and a gestational age of 30 weeks. Kangaroo Mother Care (KMC) was started in the first week of life. They found that infants in KMC had an improved oxygen saturation levels, their infants’ temperature and respiration stabilized, and heart rate was lowered by 3 to 5 beats. The mothers reported that they felt closer to their babies and that KMC elevated their mood, although they were initially frightened about trying it. The mothers also reported increased confidence in handling their babies. Health care workers reported that KMC made mothers feel more confident, increased breastfeeding, and that the babies cried less and slept more.

A study from Israel showed similar results with a larger sample (Feldman, Eidelman, Sirotla, & Weller, 2002). This study randomly assigned preterm infants to either the Kangaroo Care (KC) or standard care. The mothers were matched for birth weight and gestational age of their infants, severity of infant illness, and demographic characteristics. At 37 weeks gestation, mothers in the KC group had more positive affect, touch, and adaptation to their infants’ cues. The infants showed more alertness and less gaze aversion. The mothers were less likely to be depressed or report that their infants were abnormal. At 3 months, mothers and fathers were more sensitive and provided a better home environment (based on their score on the HOME inventory). At 6 months, the KC mothers were more sensitive to their babies’ cues, and their infants scored significantly higher on the Bayley Mental Developmental Index and the Psychomotor Developmental Index. The authors speculated that Kangaroo Care influenced infant development directly by having a positive impact on infants’ perceptual-cognitive and motor development. There may have also been an indirect impact because Kangaroo Care improved maternal mood, perceptions of their infants, and how they interacted with their babies.

Social Support Interventions

A more traditional social-support intervention also improved outcomes for mothers of premature babies (Jotzo & Poets, 2005). In this study, mothers were randomly assigned to a crisis intervention offered at 5 days postpartum or they received usual care. The intervention took place in the NICU two times a week, for 5 to 15 minutes. Elements of the crisis intervention included helping mothers reconstruct the events before and after their births, teaching them relaxation techniques, explaining stress and trauma responses, providing them with support during “emotional outbursts,” discussing with them personal resources and current support, and offering them possible solutions for concrete problems. At discharge, mothers in the intervention group had significantly lower trauma symptoms than mothers who received standard care. This study demonstrates that a relatively simple intervention can help prevent trauma symptoms in mothers of hospitalized infants.

Summary

The findings described above demonstrate that preterm delivery can lead to traumatic-stress symptoms in parents. But this reaction is not universal and by no means inevitable. Parents are more vulnerable to posttraumatic-stress symptoms if their babies are seriously ill or if they’ve experienced prior perinatal loss, a difficult birth, or other type of prior trauma. Care providers should be alert for possible depression and trauma symptoms. Two types of interventions have proven helpful in lowering the risk of depression and trauma symptoms: keeping mothers and babies together, with skin-to-skin contact, and more traditional crisis intervention.

References


Radestad, I., Nordin, C., Steineck, G., & Sjogren, B. (1996). Still birth is no inevitable. Parents are more vulnerable to posttraumatic-stress symptoms if their babies are seriously ill or if they’ve experienced prior perinatal loss, a difficult birth, or other type of prior trauma. Care providers should be alert for possible depression and trauma symptoms: Two types of interventions have proven helpful in lowering the risk of depression and trauma symptoms: keeping mothers and babies together, with skin-to-skin contact, and more traditional crisis intervention. Journal of Psychosomatic Obstetrics & Gynecology, 25, 183–187.
Member Spotlight

Div 56’s Jennifer J. Freyd Awarded UO’s “Research Innovation Award”

Jennifer J. Freyd

- Professor, Department of Psychology, University of Oregon

Degrees and Honors

BA Anthropology, 1979 (Magna Cum Laude), University of Pennsylvania

PhD Psychology, 1983, Stanford University

NSF Presidential Young Investigator Award; Fellow, John Simon Guggenheim Foundation; NIMH Career Award; Fellow, American Association for the Advancement of Science; Fellow, Center for Advanced Study in the Behavioral Sciences; U. of Canterbury Erskine Fellow

Research and Scholarly Focus

Jennifer Freyd is passionate about investigating the psychology of trauma. Freyd directs a large laboratory investigating the causes and impact of interpersonal violence, particularly child abuse, on mental and physical health, behavior, and society. Freyd’s research with both adult and child participants investigates predictions made by Betrayal Trauma Theory. Analysis of evolutionary pressures and developmental needs suggests that victims of abuse may remain completely or partially unaware of abuse and betrayal, not to reduce suffering, but rather to maintain an attachment with a figure vital to survival, development, and thriving. Highlighting social relations and trust as central to traumatic stress has challenged existing beliefs about the psychology of trauma and generates novel testable predictions. The research has led to a wide range of discoveries about the impact of betrayal trauma on humans, including the role of betrayal on memory, revictimization, perpetration, mental and physical health problems, disclosure delay, and making accurate trust decisions. The author of over 130 articles, Freyd wrote the award-winning book Betrayal Trauma (Harvard Press). Freyd is also committed to national education; for instance, she was the lead author of an influential policy article about the science of child sexual abuse published in Science. She currently serves as the Editor of the Journal of Trauma & Dissociation and Chair of the Science Committee of the American Psychological Association’s Trauma Psychology Division.

In Her Own Words

The study of trauma can be heart-wrenching, but it can also be inspiring when uncovering the causes and consequences of abuse and betrayal lets us help victims and significantly reduce the frequency of these events in the future. The psychology of trauma is also deeply fascinating, as it opens a window on the human mind and heart. I am fortunate to be in a field that is growing so quickly at the national and international level. I am also deeply appreciative of my colleagues here at the UO and around the world, my husband and children, and particularly my amazingly talented and dedicated former and current students.

Source: http://research.uoregon.edu/RIA

Division 56's Jennifer Freyd is joined at the award ceremony by her children, Philip and Sasha, and her partner, J.Q. Johnson. Her eldest son, Theo, is not pictured.

We’re interested in our Members...

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).
CALL FOR PAPERS

Child & Youth Care Forum
Carl F Weems, Ph.D., Editor in Chief
cweems@uno.edu

Special Issue: Trauma Exposure and PTSD in Justice-Involved Youth

Child & Youth Care Forum announces a forthcoming special issue on Trauma Exposure and PTSD in Justice-Involved Youth. This special issue is being edited by Keith Cruise, PhD, MLS and Julian Ford, PhD.

Manuscripts that address a wide variety of issues involving the effects of trauma exposure and PTSD symptomatology in juvenile justice populations will be considered for this special issue. Of particular interest are manuscripts that address empirical testing of screening and assessment tools, intervention outcomes, and longitudinal studies investigating a variety of outcomes (e.g., behavioral, legal, psychosocial). Manuscripts that address implementation of assessment and intervention practices across different juvenile justice settings (e.g., community, residential, detention/corrections) are especially relevant for this special issue.

The deadline for manuscripts submission is November 15, 2009. Manuscripts should be between 20-30 double-spaced typewritten pages. Manuscript submission and review will be handled through the Child & Youth Care Forum electronic submission portal (http://www.editorialmanager.com/ccar/). When electronically submitting a manuscript, indicate that the manuscript is designated for the special issue using the Editorial Manager system. The editors request that authors also provide names and contact information of three qualified reviewers with each submission.

Additional inquires regarding manuscripts for this special issue can be addressed to either Keith Cruise (cruise@fordham.edu) or Julian Ford (ford@psychiatry.uchc.edu).
Call for Nominations: 2009 APF Charles L. Brewer Distinguished Teaching of Psychology Award

The American Psychological Foundation (APF) is pleased to announce the call for nominations for the 2009 APF Charles L. Brewer Distinguished Teaching of Psychology Award. The award recognizes a significant career of contributions of a psychologist who has a proven track record as an exceptional teacher of psychology. We would appreciate your assistance in disseminating this announcement to your constituents or members.

Nominees must demonstrate the following dimensions:
- Demonstrated influence as a teacher whose students became outstanding psychologists: names and careers of nominee's students and evidence of influence as a teacher of them.
- Development of effective teaching methods and/or teaching materials.
- Engagement in significant research or other creative activity on teaching.
- Development of innovative curricula and courses: description and sample of innovation and evidence of its successful utilization.
- Outstanding performance as a teacher in and outside the classroom: student ratings, enrollment figures, evaluative observation by colleagues, teaching awards, other forms of prior recognition.
- An especially effective trainer of teachers of psychology: description of the contributions and evidence of effectiveness.
- Outstanding teaching of advanced research methods and practice in psychology (advanced undergraduate, graduate, or other): description of classroom and mentoring roles.
- Responsible for administrative facilitation of outstanding teaching: description of administrative actions and results on teaching programs; evaluation by others of actions and results.

Amount: The awardee will receive a plaque, $2,000, and an all-expense paid round trip to the APA annual convention, where the award is presented. Awardees are also invited to give a special address.

The application deadline is December 1, 2009. For more information, including the nomination procedures, please visit http://www.apa.org/apf/brewer.html.

Who Do You Know?

Rochelle Coffey, PhD, Division 56 Membership Committee Chair

Now that we're in our third year, we'd like to invite all of you to contribute to our continued membership growth through a 1-for-1 campaign. Each Division 56 member knows at least a few colleagues who do trauma research, therapy or teaching and who are not yet members of Division 56.

If you are a trauma researcher, are your colleagues and research assistants all members? Therapists, do you have people in your practice, agency or on your referral list who would like to stay current with the field? For those of you in academia, think about students who have shown interest in the trauma field (we have reduced membership fees for students). Membership in Division 56 offers a great opportunity for students to gain exposure to potential mentors in the field as well as encouraging interest and commitment to the field of trauma psychology. We encourage each one of you to recruit at least one new member to join Division 56. The following are some talking points you can use in this recruitment campaign:

1. Members will keep up-to-date on the latest development through our division's new journal—Psychological Trauma: Theory, Research, Practice, and Policy.
2. Members may choose to join a members-only listserv providing on-going conversation with others in the trauma field on the latest trends and trauma related developments in APA.
3. Members have voting privileges in the division's annual meeting and are eligible to serve on committees or run for division office, thus shaping the future of trauma psychology
4. Division 56 has a Professional Affiliate membership category that's open to any professional interested in trauma psychology—non-APA member psychologists, psychiatrists, counselors, nurses, social workers, attorneys, advocates.

Division 56 is already one of the few divisions of APA that is growing. If every member could introduce and recruit one new member to Division 56, we could double our division membership before the convention. Encourage your colleagues to check our website to find out what we've been up to, to listen to convention programs from the past three years, and to see what we did in Toronto.
Early Career Professionals/Psychologists (ECPs)

Lisa Cromer, PhD, Committee Chair

Last year Division 56 formed the Early Career Psychologist/professionals (ECP) Committee. An early career person is one who has received his or her doctoral or professional degree within the past 7 years. Many of the divisions have early career psychologist committees—we are including “professional” in the title as we welcome division members who do trauma work in other disciplines.

The ECP committee is just over a year old. The committee goal is to facilitate networking, collaboration, mentorship, and advocacy for the needs and concerns of ECPs.

The committee has completed several initiatives already. These initiatives include obtaining a $10 discount in membership fees for Div 56 ECP members, advocating for family-friendly practices (e.g., nursing rooms) at the APA convention, establishing a listserv (see the division webpage http://www.apatraumadivision.org/ for a sign-up link), and starting a Facebook group in order to facilitate networking and communication. Please join us on Facebook (search groups for “Div56 ECPN”) for a discussion on some of these topics.

More efforts are under way and input from ECPs is welcome! We want ECPs to have a regular column feature in this newsletter and are working on a clear mission statement. We are in the process of defining the parameters for a Division 56 ECP award and would like to learn about the types of training, workshops, advocacy, and mentoring that would make your membership in the division more valuable and meaningful. In order to learn how we can best meet your needs, we are conducting a needs assessment.

Please complete the anonymous ECP needs assessment questionnaire in order to help us determine the types of initiatives we should be pursuing. Whether or not you wish to be formally involved in the committee (and we hope you do!), we want you to hear from you. You can access this questionnaire at: http://www.surveymonkey.com/s.aspx?sm=nOsvEU025z0dAANdC423LQ_3d_3d

Aggregate data from the survey will be shared with the Executive Committee (EC) at the first meeting in 2010. The EC wants to hear from you as does the ECP.

If you are interested in contributing to the committee in any way, please contact me at lisa-cromer@utulsa.edu. You can also email me for the survey link above.

I look forward to meeting you on the Internet!

On behalf of the ECP committee,

Lisa Cromer, PhD
Committee Chair

Summit to End Interpersonal Violence and Abuse Across the Lifespan


One hundred and growing! That’s the number of organizations and entities that have signed on as partners for the next Summit to end interpersonal violence and abuse across the lifespan. As we write this, we are one week away from the next planning meeting for the February 24–26, 2010 Summit to be held in Dallas, Texas. This number of partners represents almost a doubling from the organizations that were working with us since our last report in the summer newsletter. Clearly the momentum continues, for moving from discussing prevention to actions that will synthesize the research base, policy recommendations, and practice interventions towards ending this tremendous toll on human and economic resources.

Participants at the 2010 Summit will experience speakers, workshops, and poster sessions that will bridge across types of violence as well as across disciplines. Each offering will have at least two foci from among the eight themes, which are: Children Exposed to Violence, Child Maltreatment, Intimate Partner Violence, Sexual Violence, Teen/Youth Violence, Community Violence, Substance Abuse, Diverse/Cross Cultural Issues. These themes are particularly salient in that it is well documented that the difficult economic times we are all living through, can escalate rates of interpersonal violence, rates that had been declining slowly in the recent past.

Speaker lists will be finalized in the next month or so as we conclude our San Diego planning meeting, but all speakers are asked to provide a cutting edge science foundation to their content, and policy implications will be threaded throughout. The format is scheduled to provide participants with opportunities for networking and for collaborating on potential projects. The conference is being planned by Reisman–White, who provided excellent meeting planning for the first Summit in 2008.

For practitioners interested in continuing education credits, up to 19 CEs will be available through the Institute for Violence, Abuse, and Trauma (IVAT). We look forward to meeting Division 56 members in Dallas, February 24–26, 2010. The Summit brochure is available at http://www.reisman-white.com/edu. You can also email me for the survey link above.

Lisa Cromer, PhD
Committee Chair

Nicole Richardson, PsyD


Welcome and Introduction
Steve Gold opened the meeting by welcoming attendees. He summarized some of the key points from the Executive Council meeting on August 6.

Update on DSM-V
Steve Gold reported on the discussion regarding the Division’s DSM-V committee. This committee will continue to monitor the progress of the work group revising the DSM. The Division is especially concerned with the PTSD and Developmental Trauma diagnoses.

Motion to Approve the Minutes from the 2009 Mid-Winter Meeting
This motion passed unanimously.

Treasurer’s Report
Beth Rom-Rymer reported that our current net income was $26,788.16. This amount was higher than expected, due in part to keeping our expenses low. The Division’s largest single expense is printing the newsletter. She did note that our corporate sponsorship was down this year, but we do have a new fundraising chair. She reviewed some other possible revenue sources for the upcoming year including increasing the number of Early Career Psychologists as member, increasing corporate sponsorship, and generating income on the Web.

Division Journal
Steve Gold, editor of the Division 56 journal, Psychological Trauma, reported on the journal’s progress. Our third issue is about to go to press. APA is very pleased with our progress so far. We have 1744 individual subscribers and 2700 institutional subscribers. These numbers are way beyond our projected numbers.

Motion to form a Committee on Collaborative Endeavors
Steve moved that the Division approve a new standing committee: the Committee on Collaborative Endeavors. This motion was approved unanimously. Connie Dalenberg will serve as Committee Chair.

Election of New Officers for 2010
The recent election of officers was as follows.

- President-Elect: Chris Courtois
- Secretary: Kathy Kendall-Tackett
- Member-at-Large: Diane Castillo
- ECP Representative: Lisa Cromer
- Student Representative: Rachel Reed

2009 Division Awards
The Division Awards were as follows.

- Distinguished Scientific Contribution: Jennifer Vasterling, PhD
- Distinguished Contribution to the Practice of Trauma Psychology: Francine Shapiro, PhD
- Service Award: Farris Tuma, ScD
- Dissertation Award: Michael Baratta, PhD
- Lifetime Achievement: Charles Figley, PhD

Motion to Add an Early Career Psychologist Award
This motion was approved unanimously.

Motion to Add a Media Award
This motion was approved unanimously.

Division Task Forces
There are currently five Task Forces within the Division. These are as follows.

- Task Force on DSM-V
- Task Force on Trauma in the Military and Their Families
- Task Force on Ethical Issues in Forensic Evaluations involving Trauma
- Task Force on Interpersonal Violence
- Dissemination Task Force

Task Forces are formed by the Division President and chairs are appointed for a two-year term. Generally, at the end of their term, Task Forces produce a product, such as a report.

Summit on Interpersonal Violence
Bob Geffner reported on the Division’s involvement in the Summit on Interpersonal Violence. This originated with the Division and now has expanded to include 17 APA Divisions and a large base of other organizations. In September, the Task Force on Interpersonal Violence will develop a blueprint on response to interpersonal violence. There is already a start-up committee and working groups.
In addressing theory as one of the four pillars of trauma psychology, I think it is useful to highlight a seismic theoretical shift in the domain of clinical psychology. I believe we would all agree that trauma psychology, from its initial emergence in the waning decades of the nineteenth century through its resurgence over the last thirty or so years, has always been strongly driven by and tied to clinical concerns. The converse, by the way, is about as true: the history of clinical psychology from its inception has been intimately bound up with and guided by appreciation of the impact of traumatic events on psychological adjustment. The sweeping transformation I am referring to is the degree to which psychoanalytic theory has been supplanted by cognitive behavioral theory as the dominant paradigm in clinical psychology. In the first half of the twentieth century, psychoanalysis was by far the most widely subscribed to model in clinical psychology. For a long time it was practically the only game in town. In many clinical training programs these days psychoanalysis—and just about any other theoretical model outside the umbrella of CBT—has been relegated to the status of a curiously amusing historical footnote.

In psychoanalysis, theory is pivotal, and clinical observation, as opposed to quantitative empirical findings, comprises the major source of data from which psychoanalytic theory has evolved. The value of clinical observation is that it yields intricate details about the phenomena of interest. One trade-off for the high level of specificity provided by clinical observations is their questionable generalizability. There is the appreciable danger of concluding that observations made within the decidedly non-random sample of individuals encountered in a particular clinical cohort are widely or even universally applicable to people in general.

Another major problem is that it is extremely difficult to exercise objectivity when making observations in a clinical situation. As a clinician, once you have developed allegiance to a particular theoretical perspective, it is more or less inevitable that the model you subscribe to will guide, shape and to a certain extent distort your observations. Of course, the direction of that distortion makes it exceedingly likely that your observations will remain firmly in line with, and therefore appear to validate, your theory. And it is just as probable that, at least occasionally, you will forget entirely that you are working with a theoretical framework and mistake the hypotheses that guide your clinical work for facts.

It was largely in response to this tendency in psychoanalysis that in the latter part of the twentieth century cognitive behavior therapy (CBT) emerged as the dominant paradigm in clinical psychology. In contrast to psychoanalysis, CBT lent itself to the formulation of scientifically testable hypotheses and therefore to development primarily via empirical research rather than clinical observation. I think most of those of us engaged in doctoral training would agree that the education of professional psychologists, both within and outside the arena
“It is ultimately the lived experience of people that is the subject matter of trauma psychology, and our field has little import if it fails to substantively impact people's daily lives.”

of trauma psychology, is increasingly dominated by CBT-based approaches.

Now, I am well aware that the very idea that there can be such a thing as an excessive emphasis on data may sound strange and even blasphemous in the context of the current zeitgeist, but it seems to me that in trying to respond to the excessive emphasis on theory in psychoanalysis, CBT has drifted in precisely that direction. By inadequately incorporating theory into our training of psychologists, we have left a considerable proportion of our trainees relatively ignorant about the role of theory in the scientific enterprise. Too many of our doctoral students have had extensive training in methodological rigor and multivariate statistical analysis, but have never acquired the intellectual tools required to adequately assess the conceptual coherence of a theory, generate alternative hypotheses or theoretical formulations, or even to fully understand that theory building requires more than a simple accretion of empirical data.

By attempting to rectify the excessive focus on theory in psychoanalysis, the fields of clinical psychology in general and that of trauma psychology in particular have too often lost sight of the reciprocal relationship between research data and theoretical conceptualization. We have elevated our focus on data to such a degree that we have forgotten that theory testing and theory building play an intrinsic role in the scientific enterprise. Genuine science requires more than technical proficiency in designing studies and collecting and analyzing data. It requires conceptual sophistication, including the willingness to be “confused by the facts,” that is, to be ready to question and revise our theoretical assumptions in the light of incoming data. Ironically, we can become so data-driven that forget that the very questions we formulate for study and consequently the data we consider relevant for collection and analysis are largely determined by our theoretical assumptions.

This brings me to the essential role of research, the second of the four pillars of trauma psychology. There still are many practitioners who subscribe to the general viewpoint that empirical studies are of little or no relevance to real-world clinical practice. It is largely for this reason that dissemination, the field of trying to figure out why practitioners stubbornly ignore the findings of clinical researchers, has in recent years grown to be a field of empirical study in its own right. The very problem—in trauma psychology as in other areas—of the failure of practitioners to attend to and adopt clinical research findings, highlights the degree to which there is a need to recognize and integrate the four main pillars of our field. Too often, researchers and practitioners live and work in parallel but decidedly separate universes.

Unlike many other fields of study, the sustained empirical study of psychological trauma is fairly young, dating back less than three decades. This makes our field a particularly good example of the relevance of research to practitioners. Empirical findings have made our understanding of trauma much more nuanced than they were just a few years ago. For example,

- At one time we thought traumatic events were “outside the realm of usual human experience.” We now know that the majority of people have been exposed to at least one traumatic event (corresponding to DSM criterion A for PTSD) in their lifetimes.
- It was once believed that almost anyone exposed to a criterion A event would develop PTSD or other psychological difficulties. We now know that for most types of traumatic events the majority of exposed individuals will not go on to manifest chronic PTSD.
- There is mounting evidence that for many people PTS symptoms that emerge within the first few weeks following trauma exposure will subside without treatment.
- Accumulating evidence suggests that exposure to a traumatic event can lead to psychological growth and increased resiliency rather than or in addition to psychological impairment.

Certainly these conclusions have relevance for clinicians. Why, then, does it remain so difficult for researchers to capture the respect and attention of practitioners? I think that at least one major reason for this is that too many of our most esteemed and prolific researchers believe that efficacy in practice can be almost entirely reduced to quantitative data about rote interventions. While clinical observation embedded in the lived experience of participant observation too easily leads to confirmation of existing assumptions and overgeneralization, there is an equally substantial limitation in the value of quantitative data divorced almost entirely from clinical observation and clinical experience. The psychological treatment of trauma-related difficulties, perhaps more than of any other area, is about real people, real lives and lived experience. An ecologically valid literature on effective trauma practice cannot be grounded solely in quantitative data removed from this lived reality. Neither can it be rooted exclusively in the intensity of lived experience to the exclusion of the objectivity of empirical research. Either extreme is like trying to walk on one leg. Researchers and practitioners in trauma psychology must learn to work together more closely and collaboratively if we are going to decisively move the field forward in a way that will truly benefit the public.

It is ultimately the lived experience of people that is the subject matter of trauma psychology. Our field has little import if it fails to substantively impact people’s daily lives.

continued on p. 26
This brings us to the fourth pillar of trauma psychology policy. Now, for those of you who haven’t yet noticed, I have rather shamelessly lifted the theme for this address from the title of the Division 56 journal, *Psychological Trauma: Theory, Research, Practice and Policy*. There are your four pillars: *Theory, Research, Practice and Policy*, ensconced in the title of our division journal.

I think there are a couple of things worth noting about the appearance of these four pillars in the journal title. For one thing, they were arrived at through discussion and consensus among the twenty-plus members of the governance of Division 56. As such, I think they are a testament to the high quality product that can be generated by collective effort. Granted, the inclusion of theory, research and practice among those pillars is pretty much a no-brainer. But consider that policy pillar. That one, I think, is pretty remarkable. If you go to this web site [http://www.apa.org/journals/by_title.html] you will find a list of the 60 journals published by APA, and if you do a search on that page for *policy*, you will find that among them, ours is the only one containing that word in the title.

The relevance of the term *policy*—an amalgam of the concepts of people (or citizens), community and government—to psychological trauma is reflected of this passage from Judith Herman’s classic book, *Trauma and Recovery*:

> To hold traumatic reality in consciousness requires a social context that affirms and protects the victim and joins the victim and witness in a common alliance. For the individual victim, this social context is created by friends, lovers, and family. For the larger society, the social context is created by political movements that give voice to the disempowered. (p. 9)

Trauma psychology is unique in this respect. It is inextricably tied to politics and policy. We cannot dispassionately conceptualize trauma, study trauma, or intervene to assist trauma survivors, while ignoring the conditions that give rise to and perpetuate traumatic events.

One of my most interesting and eye-opening experiences during my term thus far as president of Division 56 has been that repeatedly over the past six months we have been approached by individuals and institutions requesting our consultation or collaboration in trauma-related research projects, service delivery programs, and educational and training efforts. These appeals have reaffirmed to me that it is simply not possible for trauma psychologists to function effectively while segregated from the policies and politics of the larger society. Even if we attempt to do so, *people and organizations will seek us out*. If they do not, in fact, it might be cause for us to reflect on the possibility that our professional activities are entirely too removed from and inaccessible to the world at large. Those of you familiar with APA divisions will recognize that receipt of requests such as these is *highly unusual*. Most APA divisions face primarily *inward*, toward their division members and the central governance of APA. APA is, after all, a professional organization designed to serve the interests of psychologists.

In contrast, a steady pull by people and organizations unaffiliated with APA is attempting to draw the Division of Trauma Psychology *outward*, into the larger community beyond APA. To respond to these requests and engage regularly and unapologetically with the outside world is *not* APA business as usual. If we embark on this path we may well set a new precedent that other APA divisions might eventually follow. If we as a division are to be successful in moving in this new direction, we will need to proceed with a certain measure of carefulness and sobriety. But I fervently believe that proceed we must. To be true to our calling as trauma psychologists, we must be prepared to answer when the larger community *calls out to us* for our expertise and support.

It is for this reason that I have established a Committee for Collaborative Endeavors, chaired by Constance Dalenberg. The role of this committee will be to receive requests for consultation and collaboration from outside the division, to assess whether it is feasible and appropriate for Division 56 to participate in these projects, and to identify members of the Division who by virtue of their expertise and geographic location are particularly well suited to respond each request.

I will not take the time here to describe each of the specific requests for consultation or collaboration that Division 56 has received in the last few months. However, I will note that every one of these proposed projects has policy implications. Each of them has to potential to transform policy in its respective arena of focus—be it in education, the judicial system, the correctional system, the military, what have you.

In addition I have charged Joan Cook with convening a Task Force on Dissemination to examine how Division 56 can reach out to various constituencies—such as other APA divisions, psychologists in general, graduate training programs, and the general public—to increase awareness and understanding of trauma psychology. So, in terms of enterprises that have the potential to impact policy, there are outreach efforts occurring in both directions—via the Dissemination Task Force, Division 56 is exploring ways to influence social systems outside of itself; via the Collaborative Endeavors Committee, we have established a structure for receiving and examining invitations to work with those outside Division 56.

While each of the four main pillars that undergird the field of trauma psychology is essential, to be optimally effective these four arenas need to be approached in
an integrative fashion. Trauma psychology cannot be adequately supported by any one pillar without attention to and integration with the other three. A piecemeal approach will fail to do justice to the intricacies of trauma as a lived experience of real people in the real world.

This is an exciting time in the field of trauma psychology. Division 56 has greatly benefited from and wisely capitalized on the advantages afforded by the juncture at which trauma psychology finds itself at the dawn of the 21st century. Only 3 years after it came into existence, Division 56, the youngest APA division, is above the median among all APA divisions in the size of its membership. Our new journal is already inundated with submissions, including manuscripts by many of the leading figures in our field. Laura Brown and I were informed by the APA Publications Office just two days ago that fully 35% of the individuals subscribing to the journal are from outside our division. Our knowledge, resources and skills are being actively sought out by other APA divisions and by individuals and groups outside of APA. Division 56 has garnered a level of respect that belies our youth as an organization.

If as a Division and as a field we are astute enough to keep all four pillars that support trauma psychology solidly within our sights, then we will be able to look back on the present moment as the threshold of a golden age in trauma psychology, a period of influence, growth and productivity in which Division 56 assumed a decisive leadership role.

I want to thank all of you here for the substantive contributions you have made in bringing us to this juncture. It is a genuine pleasure and a great privilege to work side by side with colleagues who are so talented and at the same time so responsive to and humbled by the enormity of the human suffering at the core of our discipline. I especially want to express my gratitude to the two Division 56 presidents who preceded me—Judie Alpert and Bob Geffner, who were both instrumental in founding the Division, to Laura Brown, who, although she will be succeeding me as president, has been an invaluable and generous in mentoring me in my presidential role, and to Associate Editors Christine Courtois and Kathy Kendall-Tackett, for all the hard work they have invested in the establishment of our division journal.

We are poised on the edge of an era of tremendous opportunity to move trauma psychology forward and to be of service to society. Our knowledge and skills are sorely needed. Let us pull together to make the most of the prospects looming before us. It appears that the world is ready and eager to avail itself of what we have to offer. Now that this moment has arrived, let us ensure that we are prepared to respond to it.

Don’t Miss Any Upcoming Issues of TPN

1. Make sure that your Membership with Div 56 is up-to-date and that your current email information is on file.
2. We will automatically add emails to the listserv for paid memberships we have in our database that are NOT marked “stop bulk email.” If you have asked APA or the division not to send you emails, you will NOT be included.
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We appreciate your collaborative efforts to make this “greener” shift to an electronic newsletter version and for sharing in our global benefits—saving trees, contributing to a more eco-conscious community, and cutting costs for production, printing and mailing.
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.

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

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

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

Prevention: Develop and support prevention research and practice.

Public Education: Projects working towards public education.

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

Membership Benefits

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

Please register online at www.apa.org/about/division/memapp.html or download our brochure at www.apatraumadivision.org. You can also fax this application to (925) 969-3401 or mail the completed application with your payment to:

c/o Sandra Mattar, PsyD, Graduate School of Professional Psychology, John F. Kennedy University, 100 Ellinwood Way, Pleasant Hill, CA 94523
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<td>Protection for Medicare or Medicaid payment investigations</td>
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<td>Yes</td>
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<td>Specific deposition expense reimbursement</td>
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The TRAUMA PSYCHOLOGY NEWSLETTER is a membership publication of the Division of Trauma Psychology, Division 56, of the American Psychological Association and, currently, produced three times a year. The newsletter provides a forum for sharing news and advances in practice, policy, and research, as well as information about professional activities and opportunities, within the field of trauma psychology.

The TRAUMA PSYCHOLOGY NEWSLETTER is distributed to the complete membership of Division 56 and includes academics, clinicians, students, and affiliates who share a common interest in trauma psychology. Unless otherwise stated, opinions expressed by authors, contributors, and advertisers are their own and not necessarily those of APA, Division 56, the editorial staff, or any member of the editorial advisory board. Editorial correspondence and submissions are welcomed and appreciated. Please submit materials and references in APA style and send, via e-mail, as an attachment in Word format via e-mail, to the Editor exactly as you wish it to appear. Authors are also encouraged to submit their material along with a brief author statement and self-photo for publication use.

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<th>Authors’ Submission Deadline</th>
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<tr>
<td>December 15, 2009</td>
<td>Winter 2010</td>
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<td>April 15, 2010</td>
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<tr>
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In an effort to minimize the publication of erroneous information, each chair of a committee/advisory section is responsible for getting correct facts to us on anything related to their committee. The Newsletter Editors and the Division’s Web Master will only accept materials coming from those chairs. Anything else will be sent back to the chair in question for fact checking. Authors of independent articles and submissions are responsible for their own fact checking; this will not be the responsibility of the editorial staff.

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