

# TRAUMA PSYCHOLOGY

**AMERICAN PSYCHOLOGICAL ASSOCIATION**

## NEWSLETTER

### A View Inside

2009 Executive Committee.....	2
2009 Div. 56 APA Convention Program.....	3-5
Share the Wealth: Sponsor the Div. 56 Hospitality Suite and Social Hour.....	4
The Economic Crisis as Collective Trauma.....	5
Mixed Methodology in Trauma Psychology—A Love Story....	6-8
Div. 56 Endorses Melba Vasquez for APA President .....	8
The Abject Self: Self States of Relentless Despair.....	9-11
Medication Use for Trauma Symptoms and PTSD in Pregnant and Breastfeeding Women.....	12-15
Committee Reports .....	16-18
Who Do You Know?.....	18
Graduate Student Scholarships for Teaching the Psychology of Men CE Program at APA Convention .....	20
Ray's Race Application.....	21
Membership Application.....	22

### Presidential Voice

#### Building Bridges Within APA

*Steven N. Gold, PhD*

At the conclusion of the APA Multicultural Summit held in New Orleans in January, several APA divisions held their midwinter executive council (EC) meetings. At the suggestion of Division 56 president-elect Laura Brown, who has extensive experience in the governance of APA, I arranged to meet in New Orleans with the leadership of most of these divisions to encourage the formation of alliances with Division 56 and to explore opportunities for collaboration. I am happy to report that Laura's recommendation turned out to be excellent. The trip and resulting contacts were extremely productive—so much so, that I think it would be useful to review the outcome of those contacts in some detail. A practical reason for the extensive coverage is to encourage interested members of Division 56 to become involved in the initiatives that developed out of these meetings.

Let me start by sharing my general impressions of these meetings. Above all, I was very pleasantly surprised by the enthusiasm with which my overtures were received by almost all of the divisions I contacted. As those of you who have served on ECs of APA divisions or any

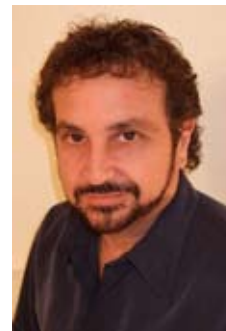
professional organization know, ECs generally meet only a few times a year, so that each meeting has an extensive agenda to cover. I was pleasantly surprised by the flexibility of the division presidents, many of whom I contacted in advance, and their willingness to rearrange their agendas to allow time to meet with me. In most cases I was able to contact the

division president in advance to request time on the EC agenda. Almost every one of them that I spoke to welcomed the request and agreed unhesitatingly.

Despite my expectation that I would need to persuade them of the relevance of our division's concerns, the leadership of every division I met with showed an immediate

understanding of how trauma psychology was related to their own area of interest and quickly formulated proposals for how we could work together toward common goals.

I started at 7:30 in the morning, meeting with Division 44, the Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues. Their president, Randy Georgemiller, graciously invited me to join them at their pre-meeting breakfast and allowed my discussion to be the first



*Steven N. Gold, PhD*

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# 2009 Division 56 APA Convention Program

APA Annual Convention  
Toronto, Ontario, Canada  
August 6–9, 2009

*Dawn Hughes and Richard Thompson*  
Program Committee Co-Chairs

This is our third year of full programming at the APA conference, and programs will include presentations of a broad range of innovative trauma research and clinical endeavors. Highlights from the Division 56 program include:

- **Helping Ourselves: Identifying and Managing Vicarious and Secondary Trauma**—This symposium, chaired by Dr. Sara Maltzman, will provide both research and clinical insights into vicarious and secondary trauma. This presentation will include a discussion of a bioecological model, with a focus on how to identify potential risk factors and ameliorate their effects. It will also include practical insights for psychologists, and for clinical supervisors and consultants.



*Dawn Hughes*

- **Empirically Supported Treatments for Childhood Trauma: Commonalities and Contrasts**—This symposium, chaired by Dr. Athena Drewes, will present three different approaches to treatment of children who have experienced trauma: trauma-focused cognitive-behavioral treatment, parent-child therapy, and EMDR. The presentations will compare and contrast these approaches, and will include not only clinical and research discussions, but also video vignettes of

the implementation of these approaches. This symposium is co-sponsored by Division 37 (Child and Family Policy and Practice).

- **Trauma Symptoms and Victimization**—This paper session will examine the outcomes and symptoms associated with a variety of trauma experiences. Dr. Courtenay Cavanaugh will discuss Intimate Partner Violence, Posttraumatic Stress Disorder, and HIV-Risk Among Women. In Trauma Symptoms in a Diverse Population of Sexually Abused Children, Dr. Elizabeth Ruiz will examine the effects of child age, gender, ethnicity and treatment on trauma symptoms in abused children. And in Cyberstalking Victimization: Impact and Coping in a National University Sample, Dr. Nancy Hensler will examine a sample that has experienced this new form of trauma.
- **Trauma Treatment in Independent Practice: Principles and Resources**—This workshop will bring together the expertise of Drs. Christine Courtois and Lenore Walker to provide a foundation in trauma-related assessment for

independent practitioners. Because most training programs do not provide extensive coverage of trauma, this is a real opportunity for clinicians who work with traumatized clients. This workshop is co-sponsored by Division 42 (Psychologists in Independent Practice). It is chaired by Dr. Dawn Hughes, and will include Dr. Melba Vasquez as a discussant.

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

- One important symposium will examine **African American Homicide Loss**, chaired by Dr. Robert Neimeyer. This program will examine the effects of homicide bereavement on African Americans, an important and overlooked issue given the high rates of homicide experienced by many African American communities.
- Race-related violence is another area that has not often received adequate attention. The symposium **Treating Trauma Resulting From Race Related Violence With Treatment Strategies Informed by Positive Psychology**, chaired by Dr. Krystal Edmonds-Biglow will explore different aspects of race-related violence, including contributing factors, clinical implications, and possible interventions. It will include a discussion about the way that positive psychology may be applied to marginalized groups, and the limits of such applications.
- **New Directions in Trauma Research**, chaired by Dr. Patricia Frazier, will provide provocative discussions of four different areas of focus in trauma psychology; specifically, this symposium will discuss: PTSD symptoms in response to events that do not meet criteria for trauma; reintegration problems and treatment needs of veterans of the Iraq and Afghanistan wars; the relationship between interpersonal traumas and trust issues in relationships; and the distinction between perceived and actual post-traumatic growth.
- **Special Issues in the Clinical and Forensic Evaluation of PTSD**, chaired by Dr. Constance Dalenberg, will address such evaluations in two types of cases that are difficult for many clinicians: elderly and cognitively impaired adults; and cases of dissociation and/or recovered memory.



*Richard Thompson*

*continued on p. 4*



## 2009 Div. 56 APA Convention Program

*continued from p. 3*

- A panel led by Dr. Elizabeth Carll will present the symposium **International Perspectives on Trauma Intervention and Training**. This symposium will feature a discussion of Interagency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial support in Emergency Settings, as well as several specific issues: trauma training in the southern Sudan, cross-cultural issues in treating refugees and torture survivors, children in armed conflict, and trauma training and intervention in the Netherlands.
- As noted earlier, most training programs in psychology still do not provide extensive training in trauma. An exciting symposium, **Trauma Courses: The Time Has Come** will make the case for including the study of trauma in mental health curricula generally. It will be chaired by Dr. Sandra Mattar, and feature Dr. Judith Alpert, Dr. Sylvia Marotta, and Dr. Priscilla Dass-Brailsford.
- **When the Stretcher is the Couch: Psychological Intervention in a Level-I Trauma Center**, chaired by Dr. Michael Nash, will be a theory- and case-based discussion of the use of psychotherapy in the emergency room setting. In addition to discussion of clinical interventions in this setting, the symposium will also deal with the experiences of clinical trainees in this setting and with working with a multidisciplinary staff who are largely unfamiliar with psychotherapy.

In addition to these symposia, we will also offer a workshop, **Dissociative Disorders: An Introduction to Diagnosis and Assessment**, led by Drs. Harold D. Siegel and Annita B. Jones, is an introductory workshop that will explain the diagnosis and assessment of dissociative disorders. At minimum, the goal of the workshop is to enable participants to rule out a dissociative disorder in their patients. The principles

of dissociation and its history will be presented. The dissociative symptom picture, with particular emphasis on Dissociative Identity Disorder ("DID"; formerly known as multiple personality disorder), will be taught. Diagnostic techniques, including tests, will be presented. There will be a review of treatment and ethical issues.

Dr. Harold D. Siegel, will also chair **Trauma, Schizophrenia, and DID: Diagnosis and Theoretical Perspectives**. This workshop will examine the links between trauma and two particular mental disorders, schizophrenia and dissociative identity disorder (DID). This workshop will also address the difficult issue of differential diagnosis between schizophrenia and DID.

A paper session titled **Trauma and Trauma-Related Symptoms in Diverse Populations** will bring together research on trauma in three disparate populations. Dr. Ibrahim Kira will discuss **PTSD, Attachment traumas and IQ: The Case of African American and Iraqi Refugee Adolescents**. Dr. Carlos Cuevas will present **Victimization and Psychological Symptomatology in a National Sample of Latinas**. And Dr. Michelle Porche will present **Past Traumas Redux: Resettled African Refugee Youth in New Hampshire**.

A second paper session, **Processes Surrounding the Responses to Trauma**, will focus on several psychological phenomena surrounding the experience of trauma. **Coping Self-Efficacy Predicts Psychological and Physical Well-Being**, presented by Abbey Valvano will provide some evidence for this link. **Guilt and Trauma: Risk Factors and Treatment Implications**, presented by Dr. Carolyn Allard, will examine the role of guilt in recovery from trauma, using insights from a clinical sample. **Structural Dissociation and Its Resolution Among Holocaust Survivors**, by Dr. Carl Auerbach, will present qualitative data on this important issue.

**Assessing and Treating Trauma in Medical Contexts**, will present some findings from this area. It will include the following presentations: **PTSD and Disability Determination**

## Share the Wealth: Sponsor the Division 56 Hospitality Suite and Social Hour

Dear Colleagues:

This is our third year of full programming at the Annual APA conference, and programs will include presentations covering a broad range of innovative trauma research and clinical endeavors. We have planned a truly exciting program this year for APA and our social hour represents a celebration of our division and a wonderful opportunity to gather as a community. However, the financial situation at this time has made finding sponsors for our social hour and hospitality suite much more difficult than it has ever been in the past. We do not want to forgo these important events. Therefore, we are inviting Division 56 members to show their support for our conference programming by assisting with the sponsorship of the social hour.

No donation is too small; any amount is appreciated. Please send a check to Division 56, with "APA 09" in the memo line to: Division 56, Division Services, American Psychological Association, 750 First St., NE, Washington DC 20002-4242

**in the Department of Veterans Affairs: Recognizing Challenges, Identifying Solutions** by Dr. Andrew Meisler, **Unexpected Deaths in Cancer Support Groups: Guidelines for Mitigating Trauma** by Dr. Karen Fergus, and **Identity, Posttraumatic Growth, and Psychological Adjustment in Adults with Cancer** by Barbara Abernathy.

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

On Friday, August 7<sup>th</sup> at 8 pm, there will be a **Social Hour** hosted by Division 56. This is still being organized, and we are looking forward to the contribution of division members to make this event a success. Please see the Social Hour and Hospitality Suite contribution solicitation on page 4.

A highlight of our program this year will be the presidential address by Dr. Steven Gold, **Keeping It Real: The Four Pillars of Trauma Psychology**. This address

will take place on Saturday, August 8<sup>th</sup> at 4 pm, followed by the Division business meeting at 5 pm.

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

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

## The Economic Crisis as Collective Trauma<sup>1</sup>

Robert D. Stolorow, PhD

What do I mean by referring to our current economic crisis as a "collective trauma"? Let me explain.

I have characterized the essence of emotional trauma (R. D. Stolorow, *Trauma and Human Existence*, Routledge, 2007) as a shattering of what I call *the absolutisms of everyday life*—the illusory beliefs that allow us to experience the world as stable, predictable, and safe. The shattering of these illusions by trauma brings us face to face with our existential vulnerability and with death and loss as possibilities that define our existence and that loom as constant threats.

I describe our era as an "Age of Trauma" because the tranquilizing illusions of our everyday world seem in our time to be severely threatened from all sides—by global diminution of natural resources, by global warming, by global nuclear proliferation, by global terrorism, and, currently, by global economic collapse. These are forms of collective trauma in that they threaten to obliterate the basic framework with which we as members of our particular society have made sense out of our existence.

For me, it was the fall of General Motors, even more than that of AIG and other financial institutions, which had this obliterating impact. I grew up in Pontiac, Michigan, where the cars with that name are manufactured and which is located 25 miles north of Detroit and 35 miles south of Flint. For me and my family and friends, GM was an unassailable absolutism, a symbol of the invulnerability and permanence of the American way of life. And now this Olympian symbol, along with other similar ones, has dissolved, leaving us as a nation collectively traumatized.



Robert D. Stolorow, PhD

It is my view that our Age of Trauma began with the terrorist attack of September 11, 2001. In horrifyingly demonstrating that even America can be assaulted on its native soil, the attack of 9/11 shattered our collective illusions of safety, inviolability, and grandiose invincibility, illusions that had long been mainstays of the American historical identity. The current economic crisis, in addition to being a collective trauma in its own right, is reanimating once again the feelings of terror, vulnerability, and powerlessness spawned by the attack of 9/11. It is what I describe as a *portkey* to retraumatization.

In the wake of the collective trauma of 9/11, Americans came under the spell of the disastrous *resurrective ideologies* offered by the Bush administration—ideologies that promised to bring back to life the grandiose illusions that had been nullified and lost. Although President Obama, by contrast, has shown that he is capable of grasping the complexities of our collective situation and of transcending divisive false polarities, I worry that Americans, in their desperation, are attributing messianic powers to him. Such messianic longings and hopes are doomed to disappointment when directed toward any finite human being with humanly limited powers and possibilities.

What do we need emotionally in our Age of Trauma? We need to be able to bring our feelings of anxiety and existential vulnerability into dialogue with our fellow sufferers, so that these painful feelings can be held and better borne within relationships—what I call a *relational home*—rather than being evaded by means of the grandiose, destructive resurrective ideologies that have been so characteristic of human history.

<sup>1</sup>Posted on the *Huffington Post* on March 24, 2009. Link to author's *Huffington Post* author archive: <http://www.huffingtonpost.com/robert-d-stolorow/>

# Mixed Methodology in Trauma Psychology—A Love Story

Editor's Note: This article is an invited submission by the Division 56 Science Committee, chaired by Dr. Jennifer Freyd.

Amber N. Douglas, PhD

In graduate school I was trained in a “Boulder Model” program that was invested in the development of strong scientists and practitioners. As part of my training, and I suspect in other similar programs, I was well versed and prepared in both experimental and nonexperimental research designs and exclusively trained in quantitative analyses. This training, stressed the power of numbers and our ability to generalize across populations using validated measures, develop norms, and infer from samples to entire populations. In contrast, my training as a clinician, emphasized the importance of developing a skill set that could be tailored to each individual client. My training stressed balance of these two roles with the implicit and explicit message that being a strong researcher would improve my clinical work and vice versa. Perhaps it was this desire for balance that I was looking for as a trauma researcher (not currently working as a practitioner) that led me to combine methods. Whatever the impetus, the result was my interest in qualitative methods that led to experimentation (no pun intended) with qualitative methods and culminated in my love for mixed methodologies

I realize that, for many, this is not new. In fact, many researchers intuitively combine qualitative and quantitative research methods without bothering with specific nomenclature. For example, investigators who include open-ended or participant-generated responses in their survey data (e.g., Classen, Field, Atkins, & Spiegel, 1998; capture participant narratives as an additional data point (e.g., Klein & Janoff-Bulman, 1996); or, an open-ended recall as part of an experimental design are all examples of mixed methods. In other studies evaluators may use focus groups with different constituent groups in their assessment of an intervention; or, in the development of assessment measures, researchers will utilize qualitative methods to generate scale items and fixed choice responses (e.g., King, King, Vogt, Kinght, & Samper). There is no hard and fast rule about what constitutes mixed methodology. My working definition is investigations which use quantitative and qualitative methods in conjunction to answer a research question or questions. While the results may differ across studies, the spirit of these integrated endeavors is similar—one approach is not more valuable than the other and has its place in the interpretation of findings. Creswell, Fetters and Ivankova (2004) provide a clear rationale for these designs; they argue that qualitative and quantitative methods, when woven together as complements, can generate a more comprehensive picture of phenomena.

Currently within the field of trauma psychology, the draw toward diverse methodologies is apparent. For example, Guay, Billette, and Marchland (2006) urged trauma researchers to implement qualitative and mixed methods to research investigations amongst other viable research methodologies. This past November John Creswell, an expert in mixed methodologies, spoke at the Conference for Innovations on Trauma Research Methods (CITRM). He eloquently identified the unique

strengths of trauma psychologists—many of whom are trained as clinicians—to *listen* to participants in their own voice—a skill that is essential to qualitative work (Creswell, 2008). However, it appears that mixed methods are underutilized within the field. My search of 13 trauma journals (*Child Abuse and Neglect*; *Journal of Aggression, Maltreatment and Trauma*; *Journal of Child and Adolescent Trauma*; *Journal of Child Sexual Abuse*; *European Journal of Trauma*; *Journal of Loss and Trauma*; *Journal of Interpersonal Violence*; *Journal of Trauma and Dissociation*; *Journal of Trauma Practice*; *Journal of Traumatic Stress Studies*; *Journal of Violence Against Women*; and *Psychological Trauma: Theory,*



Amber N. Douglas, PhD

*Research, and Practice; Trauma, Violence and Abuse*) for “mixed methods” netted only three studies. Upon closer examination, it was clear that only one study, LeCroy and Whitaker (2005), utilized qualitative and quantitative methods in their investigation; the other two articles were flagged because of the use of “mixed” and “methods” independently in the abstract. I am grateful to the reviewers of an earlier version of this article who pointed out that it is likely that many researchers are using combined methodologies but may not be using the same vocabulary as I am to describe their work. And for this reason my search strategy most likely misses some articles. To help

capture more of these investigations, I conducted another search for published articles on PsycInfo looking for “qualitative and quantitative methods.” This search produced 12 additional articles (see references for a complete list of the 13). Similarly, this search does not capture integrated investigations that are then separated and published separately.

Despite these efforts within our field, when I speak about research projects that involve qualitative and quantitative elements, I am often met with confusion from colleagues—some of whom wonder why I have not stuck with only one form of investigation; others who question whether one element is going to *really* provide any additional information to a question. These are good questions. I recognize that the design and implementation of a blended study is more time consuming and in some ways more complex than an investigation that only uses one mode of data collection. Qualitative analysis—for a relative novice like me—does take more time than the quantitative analysis to which I am accustomed. I am not 100% sure that the end result contributes more to my understanding of a particular process, outcome, or occurrence. But I think that it does; and I believe that the convergence of multiple strands of data is compelling and (at times) essential to understanding and providing a comprehensive view of a psychological process.

## Example of Mixed Method Design

Recently, a small group of students and I have worked on the implementation of a mixed method investigation. The intent and focus of this project is rooted in work of Viktor Frankl (1984) who explored aspects of individual difference in response to psychological trauma. Frankl proposed that individuals, in the light of horrific events, search to find meaning to understand and integrate stressful experiences into a coherent life narrative. This process of “narration,” providing a coherent context for traumatic



or stressful events, is theoretically and empirically linked to psychological recovery (e.g., Soloman & Siegel, 2003). Broadly, the current study examines and compares the processes of coping with stress and trauma in women. The quantitative portion of the study, which consists of self report questionnaires, will explore the role of cognitive schemas, quality of social support, and type of stressor in the management of stress and trauma symptoms, dissociation, and depression. The qualitative portion of the study consists of in-depth interviews that explore how a subset of these women describe and conceive of their ability to cope—what or who has made a difference in their lives. Taken together, the data will suggest explanatory model of the mechanisms essential to coping with stress and trauma while illuminating similarities and differences amongst the sample of participants. Thus far, 90 women have completed questionnaires; 15 of these women have also participated in interviews. Participants are overwhelmingly positive about their experiences in the study thus far. The mean age of participants is 48; 38% report earning less than \$20,000 per year. In terms of traumatic stress experiences, the vast majority of women reported some type of traumatic event (94%); 77% reported traumatic experiences as children (prior to the age 18) and adult experiences. About half of the participants meet diagnostic criteria for PTSD.

The methodological shortcomings and assumptions that are inherent in particular designs are well known. For instance, using measures with fixed choice answers restricts responses. Or, qualitative analyses are more vulnerable to the bias of the researcher. The researcher therefore takes these limitations into account in choosing instruments, designing surveys, formulating questions, conducting analyses, and drawing conclusions. As researchers, we must weigh the costs and benefits between different approaches in the design and analysis of our studies. In this mixed method study, I am interested in the process of meaning making and exploring the differences and similarities amongst women as a function of their stress and traumatic experiences. Specifically, past studies have illuminated a relationship between trauma and core schemas of oneself, others and the world. These beliefs or schemas have also been shown to place trauma survivors at risk for the development and maintenance of traumatic sequelae (e.g., Foa, Ehlers, Clark, Tolin, & Orsillo, 1999; Janoff-Bulman, 1989; McCann & Pearlman, 1990). Interpersonal traumas (i.e., rape, abuse) have far more consequences to future interpersonal relationships (e.g., McFarlane & Girolamo, 1996). While interpersonal traumas where survivors are perceived as more culpable can foster feelings of shame and self-blame. Other stressful events, such as natural disasters, are often not subject to the same types of evaluation and as a result are not as readily associated with shame (e.g., Herman, 1997). Related to this, previous research has found that social support, both quality and quantity, independent of type of traumatic stress, is related to severity of posttraumatic symptoms. That is, high quality and quantity of social support are inversely related to symptomatology (Schumm, Briggs-Phillips, & Hobfoll, 2006). While Frey and colleagues (Frey, Beesley, & Miller, 2006) found that women's relationships to close friends, mentors and communities may mitigate negative psychological outcomes. The current study includes quantitative measures of each of these elements as well as interview questions for the qualitative portion of the study. These questions will allow participants to describe (first hand and without restrictions) their experiences of coping, seeking support, and the management of symptoms.

## Analysis of Mixed Method Studies

The approach to data analysis is also compelling within mixed method approaches. For example, one approach is an exploratory sequential analysis. In this design quantitative analysis is conducted. As a follow-up to these findings, specific representative cases are selected and qualitative interviews are conducted. In this approach, the final results and subsequent interpretations are based largely on the qualitative findings (Creswell, 2008; Creswell & Plano Clark, 2007). Onwuegbuzie and Teddlie (2003) propose a confirmation model of sequential analysis, where data are collected and analysis is performed by type sequentially. The intent of this model is to confirm or test existing theory through multiple data forms to build on the existing literature. The process that the current study will use Creswell and Plano Clark (2007) describe as “triangulation.”

“Concurrent Triangulation Designs” consists of quantitative and qualitative data collection; data analysis is conducted on the qualitative and quantitative data separately using the appropriate techniques and then the results are compared and a composite model is proposed (Creswell & Plano Clark, 2007). For me, this approach is emblematic of the strengths of combining methodologies and suited the current study design. I will use a variety of quantitative techniques in the analysis of the survey data: examine differences between women who meet current diagnostic criteria for posttraumatic disorder and those who do not on the psychological adjustment and interpersonal functioning indicators and structural equation models to examine relevant causal pathways. The qualitative analysis will use Grounded Theory (Charmaz, 2008; Corbin & Strauss, 2007; Strauss & Corbin, 1991). Ideally, in this process of categorization comparisons of similar and different data elements are made resulting in a “constant comparison” to produce representative coded, categories and finally themes (Glaser, 1965). Finally, pulling the results of these analyses together to develop a model reflects the breadth and depth of the data.

Mixed methods are not appropriate for every research question. And the match between question and methodology is the most important. Choosing the appropriate methods is essential for a successful study. Although, I could not resist singing the praises of mixed methods to my colleagues, I do not suggest that this is a panacea for trauma research. Is this ode the equivalent of jumping on Oprah's couch and declaring my love? Well, no, but then again, nothing is. But my love is pure nonetheless. I think that combined approaches blends the strengths of each single mode of data collection—the nomethetic and normative perspective of quantitative measures combined with the idiosyncratic and individualized qualitative measures. The result can a model that often exceeds the sum of its parts.

*Note: Asterisks below denote articles utilizing mixed methods.*

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# Mixed Methodology in Trauma Psychology

continued from p. 7

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## Division 56 Endorses Melba Vasquez for APA President



Division 56 is proud to give its first-ever APA presidential endorsement to our founding member and first division Treasurer, Melba J.T. Vasquez, PhD, ABPP. Melba has become well-known to many psychologists through her decades of work on topics of ethical practice in psychology, multicultural competence, and women and trauma. Currently serving on APA's Board of Directors, Melba has also been President of APA Divisions 17 and 35 and the Texas Psychological Association. Her service both to APA and to psychology, and psychologists, has been impressive. Division 56's Executive Committee voted unanimously to give Melba our endorsement. We encourage members of Division to give her their #1 vote this fall, and to convey the message of our support for Melba's candidacy to your APA member friends and colleagues. If you'd like to personally endorse Melba, you may do so by going to her website, [www.melbavasquezforapapresident.com](http://www.melbavasquezforapapresident.com), where you will also learn other ways that you can support her candidacy.



# The Abject Self: Self States of Relentless Despair

Kathleen Adams, PhD

Sarah drags in 30 minutes late for group. She freezes outside the group perimeter, hovering anxiously as if to beseech the group's permission to enter. Her arms are wrapped around an enormous tote bag. She imagines herself as a hermit crab, toting her security around with her. She has been repeatedly late to group recently. The group knows she is being harassed by her boss and dares not leave the office with work unfinished if her boss is waiting for it. Still, her hovering is annoying. She is a seasoned group member and knows the ropes of group protocol. I bite back two competing urges: to snap at her to sit down already, and to smile and welcome her in. Doing neither, I ignore her, until someone else growls in exasperation: "For God's sake sit down." Sarah flinches and whines piteously that she hadn't wanted to interrupt what was obviously an important conversation. She adds that she wasn't sure whether she should come in or slip away. As she creeps into her seat she whispers, "Please don't look at me, I'm trying to be invisible." Someone quips "You couldn't have found a more effective way to bring everything to a halt than to make a big scene." Sinking more deeply into a slump, she murmurs, "I was so looking forward to being here, I'm really sorry." Within a few moments, Sarah had recovered her aplomb and launched enthusiastically into the back-and-forth of the group process, seamlessly inserting herself into the fray. She is a high-functioning attorney and most of the time presents with a beguiling smile, a rapier wit and wicked repartee. Her alter-ego resembles a timid, confused young girl who expects to be rejected, speaks in a mumbling whisper and inspires contempt. The group has just witnessed Sarah in a moment of self-abjection, a form of diffuse, unformulated enactment of traumatic affects.



Kathleen Adams, PhD

Sarah is not particularly masochistic, borderline, or manipulative. She is aware of other's needs and is emotionally responsive to them. She is not plagued with abandonment anxieties nor filled with sadistic rage towards herself or others. Rather, like many others in this paper she regresses to a wordless domain filled with the preverbal certainty of catastrophic annihilation. The patient in an abject state writhes outside the perimeter of safety in affects of horror, isolation, and dread that are fully embodied (Chefetz & Bromberg, 2004). At such moments, no safe base exists.

When the abject self is present, the patient simultaneously pleads for connection yet abrogates intimacy; all that is life-enhancing is perceived to be in the Other, for the abject self was overwhelmed or emptied out, by active violations or terrorization early in life (Bollas, 1987). Like the toddler with disorganized attachment who twirls, freezes in place or falls to the floor upon reunion with a frightening mother, the patient's abject self stills in apprehension and falls into silent misery, oscillating between staring with longing at the unattainable object of safety and turning away, gazing off /or down. The patient's acute vulnerability and dependency may trigger idiopathic reactions in the therapist based on the therapist's comfort with primitive material. The patient (via the abject self-state) is left holding an unbearable affect for which there is seemingly no resolution. In attachment terms these affects represent "fright without solution" (Hesse & Main 1999, p. 484), a form of attachment disorganization characteristic of people who experienced misattuned unpredictable, and frightening or frightened parenting, along with little or no emotional repair of distress. The abject enactment therefore constitutes "psychological performance art, complete with absorbing sensorial reality" (Chefetz, 2008, p. 23), a performance art that powerfully conveys the patient's insecure attachment status.

## Abject States: Fright Without Solution

In her opus on the powers of horror, Kristeva (1982) delineates a realm of preverbal experience permeated by affects of meaninglessness, dread, and horror. Her constructs of abject states and self-abjection are complex amalgams of identity, attachment disorganization, affect, and enactment. Although Kristeva's conceptualizations are no doubt highly relevant to the treatment of borderline spectrum patients, in this article I hope to facilitate the recognition, understanding, and management of abject self-states as they manifest in high functioning individuals who bring this complex material into their group and individual psychotherapy settings. Self-abjection in these individuals only superficially resembles the behavior of the masochistic character. Whereas the masochist suffers to gain nurturance, the abject self suffers in the certain knowledge that they are beyond help.

Individuals like Sarah who grew up under conditions of intermittent chaos and intrusion develop attachment strategies that disorganize under stress. The younger a person is when flooded with disintegrative affects, the more likely he/she will fail to integrate attachment strategies (Liotti, 2004) and will manifest dissociative features. The more a young child is unable to forge a meaningful and consistent bond with his or her parents the more desperate, alienated, bereft and *abject* he or she is likely to feel.

## Neural Networks of Suffering and Horror

Kristeva (1982) developed the constructs of abjection, abject states, affects and experience, and self-abjection in her essays about the impacts of horror and suffering in the self and other. Abject states are not easy to sit with. "The presence of the 'abject' causes us to flinch away, recoil and reject; it is the black hole, the abyss, the place in which all meaning collapses" (Adams, 2007, p. 410). In the grip of abject feelings one feels unworthy, unlovable, and in utter despair about the situation ever changing. Implicit memories of helplessness, dread, horror, and rejection are activated neurologically and communicated to others in our posture, voice and our words. Abjection is a powerful neural network combining cognitive and behavioral components, sensory images of past experience, and recollection of strong aversive emotions and over-arousal (Folensbee, 2008).

Self-abjection is an interpersonal communication, an enactment of impossible need. Whereas projective identification can partially control unbearable affects by placing them into someone else, self-abjection conveys and preserves unbearable affects in complex enactments without achieving relief. Self-abjection represents a simultaneous enactment of need, rejection,

*continued on p. 10*

# The Abject Self

continued from p. 9

horror, impossibility and worthlessness that is closer to notions about the basic fault, hostile dependency, and the black hole, than to pure object hunger. Abjection of the self constitutes an enactment of early desperation, devaluation, and nightmare, leaving the sufferer striving simply to survive (Kristeva, 1982).

The underlying world-view of abject self-states is based upon the realization that one's being was formed in the face of the impossible, the unnatural, the unthinkable, and the unspeakable. Abjection of the self repels the other as ardently, and adamantly, as it simultaneously seeks proximity and connection; the abject individual defines himself by his certainty of unbridgeable space between himself and an unattainable object. During enactments the object of attachment is perceived only as a movement of rejection/dejection through the self, "like the wind through trees... the intangible ghost of a profoundly familiar [rejecting] other who inhabits the self and becomes indistinguishable from it" (Bollas, 1999, pp. 128-134). Past blurs with present as helpless yearning and embodied recoil from old rejections oscillate in a rhythm of doom. Implicit memories of abject, desperately insecure attachment are unanchored in time and lived out in the body, along with early working models of how life works that predict catastrophic rejection: "[t]he abject has only one quality of the object – that of being opposed to [the] I ..... it is a brutish suffering that 'I' puts up with...for 'I' imagines that such is the desire of the other"(Kristeva, 1982, p. 2).

## Relentless Despair: Barrier to Relatedness

At its simplest, abjection is a fractal of failed dependency, an unbearable preverbal state akin to early childhood in which only need exists, along with an active sense of being "jettisoned, repelled, and repellent" (Kristeva, 1982, p. 1). Because abject enactments condense yearning and rejection, the state of abjection is embodied in cringing postures and enactments of *ambivalence* (rapid cycling or simultaneous movement toward and away, like the "pick me up-put me down" cries of the toddler in rapprochement): beseeching and disintegrating; desperation and recoil; raging against and pleading for understanding; worthlessness and demand. To feel abject is to plunge relentlessly into the horror of the black hole, of meaninglessness, of non-existence: "an awesome force of powerlessness, of defect, of nothingness, of "zero-ness" expressed, not just as a static emptiness but as an implosive, centripetal pull into the void"(Grotstein, 1990, p. 257). The black hole of abjection embodies 'relentless despair' about the possibility of hope for change. Since abject experience tends to be a closed loop, reiterative and autonomous from actual positive experiences, the challenge becomes timing and creation of a pathway inside. The therapist must find a way to penetrate through the despair to the dead self.

## The Abject Self in Life Metaphors

Although metaphor can sometimes be as difficult to follow as poetry (a right brain communication), metaphor can also capture and convey the essence of a dilemma in a way that straight discourse might evade. "I long for a time when clinicians routinely consider the potential for the existence of unspoken words, images, sensations, and more, that are the

unwanted property of people rendered speechless by inescapable painful experience (Chefetz, 2008, p. 38). Life metaphors, which condense the thematic narratives of a life into poetic symbolism or concretize visceral implicit memory, poignantly articulate nonverbal experience. Life metaphors abound in personal narratives, but could easily be overlooked if the therapist is not alert. Metaphors describing abject experience typically involve a level of preverbal fear, alienation, and/or deprivation for which there is no coherent language available (Chefetz, 2008). Some life metaphors are quite straightforward: Marilyn talked of loving to read books and watch movies about survival after shipwrecks or other catastrophe, like Robinson Crusoe. Other life metaphors are difficult to decipher at first. Because of the tangles and gaps extant in incoherent narrative, metaphorically rich language can appear psychotic or grossly disorganized when it actually may signify abrupt changes in self-states and/or the underlying presence of dissociative processes (ibid).

*Mariah.* Mariah experienced frantic anxiety states that tended to alienate her peers. She used to make up stories about herself in an attempt to coerce empathy from others, such as describing a time she nearly died in a house fire. She came to understand her compulsive lying as abject enactments, attempts to bridge the gap between herself and others, to convey her life long suffering and horror. Even if the stories were not factually accurate, the underlying affects of desperation, terror, and horror conveyed in these metaphoric stories aptly captured the nature of Mariah's emotional existence. Her life metaphors reveal traumatic attachment. Professionally, she is a gifted pediatrician who has a knack with anxious parents and troubled children:

I am blindfolded, stumbling through a cactus forest. I am stabbed by needles no matter where I turn. .... I am in the ocean, choking on water and pummeled by waves, terrified I am going to drown. I can't catch my breath. Then, I find myself collapsed on a beach. I cling to the warmth and solidity of the beach, digging my fingers into the sand to reassure myself I can stay put. But then the waves come and drag me out into the water again... Birds are flapping around and screams are trapped in my head... I was making chicken soup and was overcome by horror when the backbone of the chicken disintegrated in my hands; what was holding me together, would I disintegrate like that?... When my husband and I fight everything just keeps getting worse, we're in a particle accelerator chamber going faster and faster until we are smashed like atoms and then I hear glass break inside my head and we shatter into shards.

## Encased in Deadness

Psychic death is the shadow of abjection, haunting many individuals who have wrestled with horror. Psychic deadness presents clinically across a wide spectrum, ranging from characterological listlessness and anomie (Eigen, 1996) to the dissociated dead selves of individuals who have splintered under the pressure of unbearable childhood experience.

In her core, the trauma survivor remains solitary in the moment of her own extinction. No one knew her in the moment when she died without dying; no one knows her now, in her lived memory of annihilation. This place where she cannot be known is one of catastrophic loneliness...it is an area of deadness strangely infused with a yearning for life...Death has possessed her in its impenetrable solitude. But life makes her desire to be known in that solitude...(Grand, 1996, p. 4).

Boulanger (2007) introduces another dimension of the dead self: the collapsed self. Adult-onset trauma survivors, and children who endured repeated exposures to terror after they developed a sense of self, experience dissolution of the baseline sense of self, the psychobiological substrate that one normally takes for granted. The universe on which the self depends is obliterated, fractured into “before” and “after.” Whereas catastrophic psychic trauma in early childhood usually results in the dead self being cloaked and sequestered in shards of “Not-Me” dissociated self-states (Chefet, & Bromberg, 2004) leaving the rest of the personality relatively free from knowledge of trauma, in adult onset trauma it is the “Not-Me” living self that is dissociated from the parts of the self that are suffused in deadness. The self collapses rather than fractures. Memories of a non-traumatized self become blurry and unreachable. It is never clear that the trauma has been survived until the full impact of psychic annihilation has been witnessed and turned into narrative, by assembling all the bits and pieces of self experience and giving them meaning. It is “...the death that happened but was not experienced” (Winnicott, 1974, p. 106).

### Fate Versus Destiny

Abject and dead self-states feel “fated” to be denied the joys of being human that others take for granted; hence when positive moments do occur, they may flinch away instead of embracing them. Fatedness (Bollas, 1991) comprises projections of past experience into the future, manifestations of relentless despair and fear of breakdown (Winnicott, 1974). The deep-rooted fatedness of the abject state precludes efforts to build a self and a life. Destiny (Bollas, 1991), on the other hand, entails developing a vision of whom one might ultimately become, along with pursuing an active strategy for moving towards this end. Self-abjection entails an enactment of fatedness and doom, an interpersonal role of relentless despair. Over the years I have observed the power of even a spark of the destiny drive to light up the darkness of abjection. Usually the trigger is some unexpected exposure to positive affect, a dimension of neural circuitry that is sadly underdeveloped in this population. Positive experiences have incredible power to awaken latent internal strengths. Sometimes the spark is kindled by a spontaneous musing on the possibility of innate potential that was smothered by indifferent or absent parenting: “I wonder what I would have been like had I been raised by different parents?” One woman with a history of severe abuse had her life turned upside down as she happened to gaze in the newborn nursery at a hospital while visiting a friend and was filled with awe. She realized that once, long ago, she had been innocent and full of potential like those babies. A patient with external success but internal poverty grudgingly took up a volunteer position at a children’s hospital and found himself opening to the possibilities of intimacy after being asked to soothe children in the recovery room. New parents sometimes forge a fresh beginning as they determine to do better by their children than was done for them. I have seen the acquisition of a kitten or puppy melt the heart of grim old codgers who were waiting to die. Attuned psychotherapy provides multiple opportunities for threads of destiny to interweave with fatedness to alter the tapestry of life experiences and choices for the abject self.

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## Fall 2009 Issue of TPN



Topher Collier, PsyD

The Trauma Psychology Newsletter is accepting articles for the Fall 2009 issue. The deadline for submissions is **September 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).



# Medication Use for Trauma Symptoms and PTSD in Pregnant and Breastfeeding Women

Kathleen Kendall-Tackett, PhD, IBCLC, and Thomas W. Hale, PhD

Traumatic events are relatively common in the lives of pregnant and breastfeeding women. In our study, we found that 51% of new mothers had been exposed to at least one major traumatic event and multiple exposures were common. According to the National Center for PTSD, the most common traumatic experiences for women are rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse (National Center for PTSD, [www.ncptsd.va.gov](http://www.ncptsd.va.gov)). Trauma in the perinatal period can also be caused by previous pregnancy loss, preterm birth, neonatal death, or a life-threatening birth experience. Some trauma-exposed women will develop posttraumatic symptoms and others will meet full criteria for PTSD.



Kathleen Kendall-Tackett, PhD

Comprehensive trauma treatment involves a wide range of activities including patient education, peer support, EMDR, and trauma-focused psychotherapy. Clinicians treating women trauma survivors may also treat them while they are either pregnant or breastfeeding. Most of the standard treatments for PTSD are non-pharmacologic and therefore quite safe for both. But medications are also commonly used to treat PTSD and trauma symptoms. According to Friedman et al. (2009), medications have three potential benefits for patients: (1) they ameliorate PTSD symptoms, (2) they treat comorbid disorders, and (3) they reduce symptoms that can negatively affect both psychotherapy and daily living.

## Medications for PTSD and Trauma Symptoms

The decisions about medication use become more complex when treating women who are pregnant or breastfeeding (Freeman, 2008). One challenge associated with medicating pregnant and breastfeeding women is making accurate risk/benefit analyses. Are the risks associated with using medication less than the risks associated with untreated depression? In many cases, the answer is likely to be yes. But it is not a decision to be made lightly. For example, in a recent study of pregnant women with depression, more than 20% of infants with continuous exposure to selective serotonin reuptake inhibitors (SSRIs) during pregnancy were delivered preterm (Wisner et al., 2009). However, the rate of preterm birth among the mothers with *untreated depression* was also 20%. The rate of preterm birth among the non-exposed or partially exposed groups ranged from 4% to 9%. Misri and colleagues also noted that “when a clinician is faced with the dilemma of managing mentally ill pregnant women, no decision is risk free” (Misri et al., 2006, p. 1031).

With regard to breastfeeding, risk/benefit analyses must also weigh the risks of infant exposure to mother’s medications

with the risks of *not breastfeeding*, which are well-established, and can lead to significant infant morbidity and mortality. In most cases, the risks associated with breastfeeding on medication are still less than the risk of not breastfeeding or the risks of infant exposure to ongoing, untreated maternal depression (Hale, 2008).

## Transfer of Medications to the Infant in Pregnant and Breastfeeding Women

In this section, we give a brief overview of medication transfer to infants in utero and via breast milk, focusing on selective serotonin reuptake inhibitors (SSRIs). SSRIs are antidepressants and are often the frontline medications used to treat PTSD (Friedman et al., 2009). Researchers know a fair amount about how these medications affect infants after exposure in utero and via breastfeeding. This is a summary of a much larger literature. But it provides a starting place for understanding what we know about medication use in peripartum women.

**In Utero Exposure.** During pregnancy, medications transfer to babies via the placenta and amniotic fluid. The amount transferred via the placenta is significant and can equal the mother’s dose. But medications differ in terms of how much they transfer, and using a medication that transfers in smaller amounts is one strategy for selecting a medication to use during pregnancy. For example, in a study of 38 pregnant women who were taking SSRIs, antidepressant and metabolite concentrations were found in 87% of umbilical cord samples. The mean serum ratios ranged from 0.29 to 0.89. The lowest ratios were for sertraline (Zoloft) and paroxetine (Paxil), and the highest for citalopram (Celexa) and fluoxetine (Prozac) (Hendrick et al. 2003).



Thomas W. Hale, PhD

With regards to SSRIs causing birth defects if administered during pregnancy, the Sloane Epidemiology Center Birth Defects Study recently confirmed that the overall risk of having a child affected by SSRI use was only 0.2% (Louik et al., 2007). They did note increased risk of three birth defects with SSRI use in the first trimester: omphalocele and septal defects with sertraline, and the heart defect right ventricular outflow tract obstruction with paroxetine. But only 2% to 5% of infants with these defects were exposed to SSRIs.

In neonates, third-trimester exposure can lead to “discontinuation” syndrome due to SSRI withdrawal. Discontinuation syndrome includes acrocyanosis, tachypnea, temperature instability, irritability, and elevated drug levels (Oberlander et al., 2004). Fortunately, these symptoms are generally mild and self-limiting, and can be managed with supportive care. Severe symptoms are rare, and no reported neonatal deaths have occurred that are attributable to in utero SSRI exposure. Discontinuation syndrome can be distressing to both mothers and babies, but the symptoms are self-limiting, last for 24 to 48 hours, and do not require further treatment. Research from our lab also suggests that mothers who continue

on the medication while breastfeeding can ease discontinuation symptoms in their infants.

**Exposure via Breast Milk.** Infants can also be exposed to maternal medications via breast milk, but the amount of exposure is substantially less than in utero exposure. Some medications are better than others in terms of amount of exposure the infant receives. A recent meta-analysis of 67 studies of antidepressant levels in breastfeeding infants pooled data from 337 research cases, including 238 infants (Weissman et al., 2004). The researchers had access to data on 15 different antidepressants and their major metabolites. They found that antidepressants were detectable in the breast milk for all the antidepressants they studied. Fluoxetine produced the highest proportion of elevated infant levels and the highest mean infant level (Weissman et al., 2004). Citalopram was also relatively high. Only one infant across studies had an elevated paroxetine level, and that infant had also been exposed prenatally. All other infant paroxetine levels were zero, and this included three infants with prenatal exposure. Maternal dose was highly correlated with infant plasma level for citalopram. The correlation was weak for sertraline. And maternal dose did not predict infant level for fluoxetine, nortriptyline, or paroxetine. Compared with other antidepressants, fluoxetine was more likely to accumulate in breastfeeding infants.

With regard to long-term effects, the authors noted that low or undetectable infant plasma concentrations alone cannot reassure us that the antidepressant will have no effect

on the rapidly developing brain, and whether chronic, low-dose exposure poses a risk. However, they noted that the studies with asymptomatic infants are reassuring. Moreover, they noted that although antenatal exposure differs from exposure via breastfeeding, the antenatal data suggests little or no long-term effects on developmental outcomes. They noted that we must factor in whether there was prenatal exposure as that provides a “loading dose” that far exceeds any exposure from breast milk and can thus distort findings regarding exposure via breast milk. (Weissman et al., 2004).

In summary, they noted that breastfeeding infants’ exposure to paroxetine, sertraline and nortriptyline are unlikely to have detectable or elevated plasma drug levels. In contrast, infants exposed to fluoxetine had higher medication levels, especially if they had also been exposed prenatally. Citalopram may lead to elevated levels in some infants, but more data are needed. Although these appear safe for the majority of babies, some adverse effects have been identified through case studies. Therefore, breastfeeding mothers should be advised to watch for any possible signs of adverse reactions including irritability, poor feeding, or uneasy sleep. Premature babies or other with impaired metabolite efficiency should especially be monitored for adverse effects (Weissman et al., 2004).

### Medications for PTSD in Pregnant and Breastfeeding Women

Two recent articles have outlined the state of the art in terms

of medication choices for trauma symptoms and trauma symptoms and PTSD (Alderman et al., 2009; Friedman et al., 2009). The classes of medications used to treat PTSD include SSRIs, SNRIs, mirtazapine, SARIs, adrenergic agents, and atypical antipsychotics. Benzodiazepines, anticonvulsants, cyproheptadine, and buspirone cannot be recommended at this time (Friedman et al., 2009).

In each of these classes of medications, there are safer choices for pregnant and breastfeeding women. In perinatal health, the standard reference regarding medication use in this population is *Medications and Mothers’ Milk* (Hale, 2008). Following this article is a summary of current medications recommended for trauma symptoms/PTSD, with their pregnancy and lactation risk categories. The pregnancy risk categories are based on U.S. FDA guidelines.

### Antidepressants

#### Selective Serotonin Reuptake Inhibitors (SSRIs)

SSRIs address all three symptom clusters of PTSD: intrusive thoughts, avoidance and numbing, and hyperarousal (Friedman, 2001; Friedman et al., 2009). In the U.S., sertraline (Zoloft) was the first SSRI that was FDA-approved as a treatment for PTSD. Paroxetine (Paxil) is the treatment of choice in the U.K. and the only drug listed with a current U.K. product license for PTSD (National Institute for Clinical Excellence, 2005). Zoloft is also

Table 1  
FDA Pregnancy Risk Categories

Pregnancy Risk Category	What it Means
A	Controlled studies in women fail to demonstrate a risk to the fetus in the first trimester (and there is no evidence of a risk in later trimesters) and the possibility of fetal harm appears remote.
B	Either animal-reproduction studies have not demonstrated a fetal risk, but there are no controlled studies in pregnant women; or animal-reproduction studies have shown an adverse effect (other than a decrease in fertility) that was not confirmed in controlled studies in women in the first trimester (and there is no evidence of a risk in later trimesters).
C	Either studies in animals have revealed adverse effects on the fetus (teratogenic or embryocidal, or other) and there are no controlled studies in women, or studies in women and animals are not available. Drugs should be given only if the potential benefit justifies the potential risk to the fetus.
D	There is positive evidence of human fetal risk, but the benefits from use in pregnant women may be acceptable despite the risk (e.g., if the drug is needed in a life-threatening situation or for a serious disease for which safer drugs cannot be used or are ineffective).
X	Studies in animals or human beings have demonstrated fetal abnormalities, or there is evidence of fetal risk based on human experience, or both, and the risk of the use of the drug in pregnant women clearly outweighs any possible benefit. The drug is contraindicated in women who are or may become pregnant.

continued on p. 14

# Medication Use for Trauma Symptoms...

continued from p. 13

the preferred SSRIs for breastfeeding mothers because its inert metabolites mean that babies are exposed to less than one percent of the mothers' dose (Hale, 2008). Paxil also results in low levels of exposure for breastfeeding infants, but there is currently a black-box warning against using it during pregnancy. Lexapro (escitalopram) is another good choice for breastfeeding mothers.

Other SSRIs, including fluoxetine (Prozac) and citalopram (Celexa), can also be used to treat PTSD, but result in higher levels of exposure for infants. None of these are contraindicated for breastfeeding mothers, but sertraline, paroxetine and escitalopram are better choices whenever possible (Hale, 2008).

## Newer Antidepressants

Some newer types of antidepressants can also be used (Friedman et al., 2009). These include venlafaxine (Effexor) and mirtazapine (Remeron). Venlafaxine is a selective norepinephrine reuptake inhibitor (SNRI) and is a frontline treatment for PTSD. Mirtazapine is also showing promise (Friedman et al., 2009). Both have a rating of L3 ("moderately safe"), and should be prescribed only if the benefit outweighs the potential risk to the infant (Hale, 2008).

## Serotonin-2 Antagonists/Reuptake Inhibitors (SARIs)

Trazodone (Desyrel) is a SARI with modest efficacy, but can be a useful adjunctive treatment to promote sleep (Friedman et al., 2009). Trazodone suppresses REM sleep, which reduces the number of nightmares patients experience (Lange et al., 2000). Because trazodone is a sedative, breastfeeding women should not share a bed with their babies while taking it. (Nefazodone, the other medication in this class, has been removed from the U.S. market due to liver toxicity.)

## Adrenergic Agents

The adrenergic agents are another class of medications used to treat trauma symptoms/PTSD. Adrenergic agents work by blocking norepinephrine receptors and include clonidine (Catapres) and guanfacine (Tenex). (Propranolol [Inderal] is also used, but *not* when a patient has comorbid depression [Friedman, 2001].) Adrenergic agents are frequently prescribed to control hypertension, but in patients with PTSD, they also control symptoms of intrusive memories and hyperarousal. Prazosin (Minipress), an alpha blocker, can be helpful in reducing PTSD-related nightmares (Friedman et al., 2009), but has a rating of L4 ("possibly hazardous"), and should be used with extreme caution in breastfeeding women.

Clonidine is excreted into human milk, with the baby receiving about 6.8% of the mother's dose. It may also reduce prolactin,

which can influence milk production (Hale, 2008). Guanfacine has not been studied with regard to human milk. However, since this medication has low molecular weight, a high volume of distribution, and penetrates the central nervous system at high levels, it is likely to penetrate the milk, so caution is advised (Hale, 2008).

## Atypical Antipsychotics

Atypical anti-psychotics may also be added to the treatment regimen as an adjunct therapy for partial responders. These medications may help lessen anxiety responses. The medications within this class include risperidone (Risperdal), quetiapine (Seroquel), and olanzapine (Zyprexa). Olanzapine and quetiapine are rated L2. Risperidone has a risk category of L3. All have a C rating for use during pregnancy.

## Summary

Although medications are not the central treatment modality for PTSD, they can be helpful in women's recovery. Medications can be used safely in pregnant and breastfeeding women with

Table 2  
Lactation Risk Categories

Lactation Risk Category	What it Means
L1: Safest	Drug has been taken by a large number of breastfeeding mothers without any observed increase in adverse effects in the infant. Controlled studies in breastfeeding women fail to demonstrate a risk to the infant and the possibility of harm to the breastfeeding infant is remote; or the product is not orally bioavailable in an infant.
L2: Safer B	Drug that has been studied in a limited number of breastfeeding women without an increase in adverse effects in the infant. And/or the evidence of a demonstrated risk which is likely to follow use of this medication in a breastfeeding woman is remote.
L3: Moderately Safe	There are no controlled studies in breastfeeding women, however, the risk of untoward effects is possible; or controlled studies show only minimal non-threatening adverse effects. Drugs should be given only if the potential benefit justifies the potential risk to the infant. New medications that have absolutely no published data are automatically categorized in this category, regardless of how safe they may be.
L4: Possibly hazardous	There is positive evidence of risk to a breastfed infant or to breast milk production, but the benefits from use in breastfeeding mothers may be acceptable despite the risk of the infant (e.g., if the drug is needed in a life-threatening situation or for a serious disease for which safer drugs cannot be used or are ineffective.)
L5: Contraindicated	Studies in breastfeeding mothers have been demonstrated that there is significant and documented risk to the infant based on human experience, or it is a medication that has a high risk of causing significant damage to an infant. The risk of using the drug in breastfeeding women clearly outweighs any possible benefit from breastfeeding. The drug is contraindicated in women who are breastfeeding an infant.

From Hale, T. (2008). *Medications and Mothers' Milk* (13th ed.). Amarillo, TX: Hale Publishing. Used with permission.



trauma symptoms and there are safer choices within each medication category. Medications can also be used in addition to traditional trauma treatments, such as EMDR, psychotherapy, peer support, and psychoeducation.

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Table 3  
Pregnancy and Lactation Risk Categories for Medications for PTSD

Medication Classification	Medication Names	Pregnancy Risk Category	Lactation Risk Category	Symptoms Addressed
Selective Serotonin Reuptake Inhibitors (SSRIs)	Sertraline (Zoloft) Escitalopram (Lexapro) Paroxetine (Paxil) Fluoxetine (Prozac) Citalopram (Celexa)	C C D C C	L2 L2 L2 L2 L2	Well-tolerated; addresses comorbid symptoms; leads to global improvement and enhanced quality of life
Mixed-function Antidepressants	Venlafaxine (Effexor) Mirtazepine (Loniten)	C C	L3 L3	Demonstrated efficacy in PTSD
Serotonin-2 Antagonists/Reuptake Inhibitors (SARIs)	Trazodone (Desryl)	C	L2	Lowers incidence of nightmares by reducing REM sleep. Sedating, mothers cannot bedshare with their babies while on this medication.
Adrenergic agents	$\alpha$ -2 adrenergic antagonists (prazosin, clonidine, guanfacine)  $\beta$ -adrenergic blockers (propranolol)	C, C, B  C	L4 L3 L3  L2 L2	Blocks norepinephrine, decreases nightmares and intrusive thoughts.  Acute administration may prevent long-term symptoms. Some concern about this medication when there is comorbid depression.
Atypical Antipsychotics	Olanzapine Quetiapine Risperidone	C C C	L2 L2 L3	These can be useful adjuncts for co-occurring psychotic symptoms or when first-line medications have failed. Can also help with extreme hypervigilance/paranoia, physical aggression, trauma-related hallucinations

## COMMITTEE REPORTS Dissemination Task Force Seeks Your Input

Our current Division president, Dr. Steven Gold has a theme for the coming year: *Increasing Awareness of Trauma and Its Impact*. As such, he created a Dissemination Task Force to primarily identify ways that the Division can make trauma-related professional knowledge and skills more accessible to psychology trainees and psychologists. Secondly, a goal is to make Division 56 a more visible and effective source of information to other mental health trainees and professionals, the media, and the general public.

A well regarded group of individuals has been assembled to think through these issues over the next year:

### Chair

- Dr. Joan Cook from Yale University and National Center for PTSD

### Members

- Dr. Thema Bryant from Pepperdine University
- Dr. Christine Courtois from Christine A Courtois, PhD, & Associates, PLC



Dr. Joan Cook

- Dr. Anne DePrince from University of Denver
- Dr. Diane Elmore from the American Psychological Association
- Dr. John Fairbank from Duke University/National Child Traumatic Stress Network
- Dr. Jennifer Freyd from University of Oregon
- Dr. Steven Gold from Nova Southeastern University
- Dr. Gilbert Reyes from Fielding Graduate University
- Dr. Kevin O'Brien from the National Center for Victims of Crime
- Dr. Barbara Rothbaum from Emory University
- Dr. Josef Ruzek from the National Center for PTSD/Stanford University

In brief, over the next two years, the Task Force will generate ideas and then more detailed proposals for achieving dissemination goals, such as development of a core curriculum in trauma psychology. Throughout this time, the Task Force will distribute recommendations to the Division 56 leadership, who will then determine proceeding steps toward implementation.

If any Division 56 member would like to share their dissemination ideas on "getting the word" out about trauma psychology, please feel free to send them to the Chair of the Task Force, Dr. Joan Cook at [Joan.Cook@yale.edu](mailto:Joan.Cook@yale.edu).

## Summit on Interpersonal Violence and Abuse Across the Lifespan: Report on the Conference Planning Meeting, February 2009, New Orleans, LA

*Sylvia A. Marotta, PhD, The George Washington University, and Nicole Richardson, PsyD, John D. Dingell VAMC, Co-Chairs of the Div. 56 Task Force on Interpersonal Violence, and representatives of Div. 56 on the Summit 2010 Planning Group.*

This report presents the ongoing efforts of the Task Force on Interpersonal Violence to represent the Division in planning and implementing a long-term agenda for the prevention of interpersonal violence and abuse across the lifespan. Previous task force reports can be found in the Spring and Fall 2008 Div. 56 newsletters. The planning process has evolved to an informally named National Partnership comprising at this writing more than 50 associations and other entities, organizing to collaborate on a long term agenda. Over a 3–5 year period, the major goal of the Partnership is to make violence prevention a national priority in terms of policy, collaboration among major



Sylvia A. Marotta, PhD

professional organizations, and general public awareness. We are reporting on the February 2009 planning meeting held in New Orleans, LA, with a goal of organizing the Second Summit meeting on February 24–26, 2010, in Dallas, Texas. The Second Summit builds on the first meeting held in Washington, DC, in 2008, and that summit was followed by a think tank in September 2008. Part of the planning in New Orleans was to identify funding sources for the meeting, and to begin to sketch out the structure of the February 2010 meeting. Given the current status of the economy, funding is a challenging effort, as professional associations are affected along with everyone else. Funds are being dedicated, however, and our partners continue to grow, offering monetary as well as human resource support.

Another major focus of our planning was to design the format and structure for the meeting. Summit logistics will be managed by Reisman & White, who helped with the first Summit last year. In terms of format for the meeting, the group decided to expand to three days to allow for more



Nicole Richardson, PsyD

in-depth exposure of participants to the session content and the expected actions that will flow from the Summit. The overarching agenda for all Summit initiatives is to bridge across the participating disciplines, and to integrate the various types of interpersonal violence and abuse over the entire lifespan. The Summit will keep the momentum going for the whole ecology of science, services of all kinds, and policy issues engendered by reducing the impact of interpersonal violence and abuse in our communities. The Summit will also make use of new technologies, and while the specifics are not yet finalized, might include podcasting and other interactive technologies to allow for real-time data gathering and future access to session content. One

primary 'deliverable' at the end of the second Summit will be an organized network, providing a critical mass that can integrate and bridge the good efforts of the many individual associations working in this field. A preliminary list of tracks was generated, including intimate partner violence, child maltreatment, youth, sexual assault, children exposed to violence, community violence, and a cross-cutting diversity theme. Anyone with suggestions for developing these tracks is welcome to contact us (syl@gwu.edu; nicole.richardson@va.gov) and we will compile your suggestions to take with us to the next planning meeting in September, 2009. In the meantime, save the dates **February 24-26, 2010**, in Dallas, Texas.

## A Time of Growth and Transition—A Re-cap of the Student Affairs Committee and New Opportunities

*Gabriela Bronson-Castain, PsyD*  
*John F. Kennedy University*

In 2006, along with all of the other initial committees to the newly established Division 56, the student affairs committee began. The first student co-chairs, Emily Jacob Snow and Kathryn Dale, discussed their plans to develop a strong student presence in the division. They hoped that the student



*Gabriela Bronson-Castain, PsyD*

affairs could establish a "nationwide network of fellow students to have a forum to share in collegial dialogue with one another" and wanted to "stimulate academic conversations and happenings regarding cutting-edge work within the field of trauma." In 2007, Patrick Meade from New York University took over the student representative position on the division's executive council and has since overseen a number of projects

that the student affairs committee has undertaken. Over the past three years, the student affairs committee has focused on three main areas: membership, mentorship and the overall plan to give students a voice in the trauma community. As the publication chair of the student affairs committee, I would like to take this opportunity to recap the work done by the committee over the past two years.

### Student Membership

Jill West from Tulane University, the former student membership chair, has worked to develop a database of all accredited APA programs in Clinical Psychology, Counseling Psychology and School Psychology. This database, which includes contact information for each academic department, allows us to send emails to each program with information about the division and invitations for students to join. This has been used in the recruitment of student members and will continue to be used to circulate information about student events and publicize division wide events.

### Mentorship

The Division 56 student affairs committee launched a Student Mentorship Program at the APA conference in August 2008. Brian Hall from Kent State, the chair of the mentorship committee, designed this program to facilitate connections between student members and full members of Division 56 in order to cultivate a relationship that will be mutually beneficial to both. The purpose of the program is to provide students opportunities to reach out to mentors in the field of traumatic stress who are willing to share their expertise. We believe that this will foster better connectedness within our division and provide opportunities for our community to continue to grow and thrive. The committee developed two recruitment forms: one for interested students and one for the prospective mentors. These forms contain information regarding research and clinical interests of both the students and the full division member and what each would desire in a mentorship relationship (e.g., learn more about trauma research methods; share my expertise in working with childhood trauma). Students and mentors commit to at least six months, with the option of continuing on or being rematched. These forms are available on the division's website. The mentorship program is continuously being reviewed, and an option for future development is the implementation of a mentorship matching program based on personal introductions at events such as APA.

### Voices from the Classroom

Since the launch of the *Trauma Psychology* newsletter, the student affairs committee has worked hard to support the growth of the student population interested in the field of trauma, discuss topics relevant to students, and promote a sense of community among students. Numerous articles have been published which have featured student dissertations, pre-doctoral intern training needs in the field, and the general promotion of student participation in the division. The topics are usually determined during bi-monthly conference calls where each member of the committee reports back on their own subcommittee. This generates new topics based on direct feedback from other student

*continued on p. 18*



## A Time of Growth and Transition

*continued from p. 17*

members or observations the committee members have made as members of their own student body. This collaborative approach has stimulated interesting discussions and provided a sense of cohesion that otherwise would have been difficult to establish given our distant locations.

### New Leadership

The life of a student is filled with many transitions. We come to school to learn, we take what we have learned and put it into practice, and returned to school to learn some more. This pattern of learning goes on for many years, during which time we have many opportunities to make mistakes, find our callings, and refine our theoretical beliefs.

I became involved with the division approximately two years ago as I was completing my doctoral coursework at John F. Kennedy University in California. Dr. Sandra Mattar, one of my core faculty, asked if I would be interested in getting involved with the newly developed Division 56. Dr. Mattar had taken on the responsibility of chairing the membership committee for the division. I was well acquainted with Dr. Mattar because her trauma class had reconstructed the ways in which I understood trauma and the etiology of various psychopathologies. I found my trauma class to be one of the most useful and applicable classes in my formal education, and it has continued to serve as a cornerstone in my conceptualization of patients who have experienced various forms of trauma. I researched the division and ultimately took the

position for two reasons: (1) because I firmly believed in trauma work and was excited to work alongside leaders in the field of trauma and (2) my core faculty and a deeply respected mentor believed that my involvement could, in some way, contribute to the field of psychology.

I bring this up as a reminder to those faculty, supervisors, and mentors that take a vested interest in our growth as students. Although highly motivated, I was uncertain that there was a place for my voice in a professional community. With encouragement, I've been able to find a position where I can contribute to the division, remain a student, and challenge myself to take on new responsibilities. As I finish up my post-doctoral training and my role as publications chair for the student affairs committee, I'm excited to make room for the next generation of student affairs members.

There are currently at least two new openings on the student affairs committee. The publication chair of the student committee is responsible for recruiting students to write articles for the *Trauma Psychology* newsletter, and participate in the student affairs meetings. And the newly developed technology chair will be responsible for helping create a separate student section on the Division 56 website which may utilize an email discussion list, a forum or a blog to support student involvement.

*We look forward to hearing from all students. Student affiliates that are interested in writing for an upcoming article in Voices from the Classroom should email us at [gbcastain@jfkku.edu](mailto:gbcastain@jfkku.edu). If you are not currently a student member of Division 56, you can join going on to the Division 56 website. If you have further questions about participating on the student affairs committee please contact Patrick Meade at [pm1nyc@aol.com](mailto:pm1nyc@aol.com).*

## Who Do You Know?

*Rochelle Coffey, PhD, Division 56 Membership Committee Chair*



*Rochelle Coffey, PhD*

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 academe, think about students who have shown interest in the trauma field (we have reduced membership fees for students). Membership in Division 56 offer 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 out 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'll be doing in Toronto.

## Presidential Voice: Building Bridges...

*continued from p. 1*

item on their agenda, immediately following breakfast. As soon as I explained my reason for being there, it was clear that the members of their EC were enthusiastic that Division 56 was seeking a collaborative relationship with them. Several members of their EC readily identified areas of common interest between Divisions 44 and 56. These included school bullying in particular and more generally the impact of interpersonal violence trauma on LGBT youth and older adults. They also noted that Division 44 has established a Health Initiatives Task Force that was formed to promote attention to the health concerns of the LGBT in medical facilities and in particular in the U.S. Department of Health and Human Services Healthy People 2020 plan (see <http://www.healthypeople.gov/HP2020/>). Division 56 was encouraged to support Division 44 in their work to ensure that health disparities and equal access to health services for LGBT are addressed by the medical community.

The next group I met with was Division 17, the Society of Counseling Psychology. Despite the fact that it is a much longer established division than 44, their EC seemed similarly pleased by our division's outreach effort. Although I had been unable to reach their president, Janet Helms, before arriving in New Orleans, she was willing to accommodate my last minute request to briefly speak with their leadership. Before their meeting convened, I was introduced to their vice presidents for Diversity and Public Interest (Roger Worthington), Education and Training (Barry Chung), Science Affairs (Bob Lent) and Professional Practice (Michael Duffy), all of whom were warmly receptive. Division 17 Council Representative Louise Douce proposed that we develop a joint project with their Section on University and College Counseling Centers to train university and college counseling center staff to work with returning war veterans with PTSD and traumatic brain injury. She also suggested preparing counseling center staff to treat rape trauma, war trauma in international students, and childhood trauma that students often first acknowledge and begin to address after they leave home for college. I thought this was a particularly exciting suggestion. It certainly aligns well with the focus I am encouraging for Division 56 this year on disseminating knowledge about trauma psychology.

Chair of the Division 56 Task Force on Diversity Priscilla Dass-Brailford also serves as the Secretary-Elect of Division 45, the Society for the Psychological Study of Ethnic Minority Issues. She was extremely helpful in facilitating my access to Division 45's EC meeting even though I had not been able to make prior arrangements with their president, J. Manuel (Manny) Casas. The Division 45 EC was extremely pleased that Division 56

was initiating contact with them and inviting the establishment of a collaborative relationship. By the time I left their meeting, Division 45 Member-at-Large Cheryl Talley had already stepped forward and asked to be appointed liaison to Division 56.

By midday, I had already met with four divisions. Every one of them was enthusiastic about partnering with Division 56 and generated concrete suggestions for implementing an alliance. I was, frankly, surprised that things were proceeding so smoothly.

I had been able to make contact with the leadership of Division 39 (Psychoanalysis) in advance. They invited me to join their EC for lunch at noon and reserved a place for me on their agenda. As had been the case with the other divisions I had met with, the governance of Division 39 was extremely welcoming. In my remarks to them I noted that their division was instrumental in the creation of Division 56. For several years those interested in establishing a division of trauma psychology met at the APA Annual Convention. Division 39 had made their hospitality suite available as a venue for most of those meetings, and had been actively supportive in our lobbying efforts with APA. There is therefore a well-established affinity between 39 and 56.

In discussing areas of possible collaboration, the members of the Division 39 board raised two areas of concern that they would like Division 56 to work with them to address. One was the area of privacy of client records. The growing risk of violation of client privacy via computerization of medical records and access to these records by third-party payers was referenced. While this would certainly be a potential concern for any clients, it was noted that trauma survivors are likely to be especially sensitive to issues of violation.

A second area of collaboration identified by the EC of Division 39 as appropriate for developing as a joint endeavor with Division 56 was making information about psychological trauma more accessible to the general public. This objective fits precisely with the theme I have advanced for Division 56 in 2009, *Increasing Awareness of Trauma and Its Impact*. Members of Division 39's executive council stressed the importance of eliminating professional jargon in communications to the general public about psychological trauma so that the material is readily comprehensible and unambiguous.

My first meeting in the afternoon was with Division 35, the Society for the Psychology of Women. Division 35 president Martha Banks was extremely gracious in both granting me a place on the agenda of their executive council meeting when I had contacted her a few weeks earlier and in supporting the affiliation between Divisions 35 and 56 during the meeting itself. Division 35 program chair for the 2009 APA Convention, Phi Loan Le, encouraged Division 56 program co-chairs,

*continued on p. 20*



## Save the Date!

**APA 117th Annual Conference  
Toronto, Canada  
August 6–9, 2009**

## Presidential Voice: Building Bridges...

*continued from p. 19*

Richard Thompson and Dawn Hughes, to join her in identifying presentations suitable for co-listing in the convention program book, a task she has already accomplished. Division 56 was also urged to work with Kim Reed, co-chair of the Division 17/35 Joint Task Force on Guidelines for Psychological Practice with Girls and Women to adopt the spirit and content of the guidelines. A copy of this document can be accessed at <http://www.apa.org/about/division/guide.html> (click on Guidelines for Psychological Practice with Women and Girls).

The last meeting of the day was with Division 48. Often referred to simply as the Division of Peace Psychology, the full name is the Society for the Study of Peace, Conflict and Violence. Clearly their foci have a direct and obvious overlap with ours. Julie Levitt, their program chair, urged our program chairs for the 2010 APA Convention to coordinate with her to develop joint programming. Member at Large Judy Kuriansky encouraged Division 56 to join Division 48 in lobbying for the establishment of a Department of Peace by the U.S. federal government, with plans to subsequently advocate for a similar department at the United Nations. Division 56 was also invited to become involved with the U.N. Working Group on Trauma.

Division 42, Psychologists in Independent Practice, was unable to place me on their agenda during their executive council meeting in New Orleans. However, their president, Tammy Martin-Causey, was extremely open to scheduling a phone conference with me. We spoke just a few days before the deadline for divisions to have their program schedule submitted for the APA Annual Convention, and she suggested that our divisions do a joint presentation at the convention. We planned a workshop on Trauma Treatment in Independent Practice to be conducted by

Chris Courtois, Lenore Walker and Melba Vasquez, all of whom are fellows of both Divisions 42 and 56. Tammy also indicated that Division 42 is rebuilding their web site, and that it will be very interactive, so that it will be able to accommodate trauma-related links to provide trauma training and trauma resources.

In addition to the specific collaborative endeavors that emerged from these discussions and the increased visibility for Division 56 created by the meetings, an additional benefit has already materialized: the recruiting of liaisons to Division 56. They are David Pantalone (Division 44; [dpantalone@suffolk.edu](mailto:dpantalone@suffolk.edu)), Louise Douce (Division 17; [ldouce@studentlife.osu.edu](mailto:ldouce@studentlife.osu.edu)), Cheryl Talley (Division 45; [talleyce@cisat.jmu.edu](mailto:talleyce@cisat.jmu.edu)), Nnamdi Pole (Division 45; [npole@smith.edu](mailto:npole@smith.edu)), Tamara Greenberg (Division 39; [tamaragreenberg@gmail.com](mailto:tamaragreenberg@gmail.com)), Julii Green (Division 35; [jgreen@medicine.nodak.edu](mailto:jgreen@medicine.nodak.edu)), and Judy Kuriansky (Division 48; [DrJudyK@aol.com](mailto:DrJudyK@aol.com)). Thema Bryant-Davis ([Thema.S.Bryant-Davis@pepperdine.edu](mailto:Thema.S.Bryant-Davis@pepperdine.edu)) also agreed to serve as Division 56 liaison to the APA Committee on International Relations. In almost every instance, the participation of individuals who were not previously active in Division 56 has been enlisted, expanding the pool of those involved in our governance process.

By reaching out to other groups within APA, we have forged ties with other divisions and increased the diversity of representation within our own division. This achievement will provide a stronger foundation for outreach beyond APA. From this platform, the Dissemination Task Force, Education and Training Committee, Practice Committee and Science Committee will be better positioned to implement the Division theme of *Increasing Awareness of Trauma and Its Impact* by dispersing trauma-related knowledge to mental health professionals, scientists, policy makers and the general public. I will be providing an update on Division 56's progress toward this goal in the next issue of the newsletter.

## Graduate Student Scholarships for Teaching the Psychology of Men Continuing Education Program APA Convention in Toronto

Teaching the Psychology of Men will be a Continuing Education Program during the APA Convention in Toronto. Eight or more scholarships will be awarded to graduate students who want to attend the workshop free of charge. Issues related to the psychology of men and masculinity are increasingly identified as important areas in psychology including boy's and men's development across the life-span, issues of multiculturalism and sexual orientation, violence against women, homophobia, fathering, men's health and others. Therefore, the teaching of the psychology of men is central to psychology, yet one of the least developed areas in psychology.

The purpose of this introductory workshop will be to assist psychologists in developing course work on the psychology of men using the theoretical and empirical literature on men and masculinity. Participants will learn basic knowledge on how to create a psychology of men course or how to infuse this content into existing courses on gender or the psychology of women. Each presenter will share their syllabi, reading materials, class manuals, evaluation processes, and other resources. The workshop will discuss pedagogical processes such as traditional lecturing, psychoeducational techniques, group discussion

approaches, use of video media, student assessment techniques, managing classroom problems, and the infusion of diversity and multiculturalism as critical content.

The goals of the workshop are to help psychologists: (1) Design a psychology of men course or incorporate the psychology of men into existing courses; (2) Locate syllabi, core concepts, readings, media, self assessments, and other resources to teach the psychology of men; (3) Utilize multiple teaching methods when teaching the psychology of men including psychoeducational and multicultural approaches; and (4) Enumerate the critical problems/dilemmas and solutions when teaching the psychology of men.

The teaching faculty of the workshop include: James M. O'Neil, PhD, University of Connecticut, Chris Kilmartin, Mary Washington University, Mark Kiselica, The College Of New Jersey.

Information about the graduate student scholarships, how to apply, criteria for selection, and the deadline date can be obtained by emailing Jim O'Neil, Chair, Committee on Teaching the Psychology of Men, Division 51 of APA, at: [jimoneil1@aol.com](mailto:jimoneil1@aol.com).

Registration For APA Continuing Education Programs Begins May 1, 2009. Call 1-800-374-2721, ext. 5991. Online Registration at [apa.org/ce](http://apa.org/ce)



APA Division 47: Exercise and Sport Psychology

Presents

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Shirt Size: S M L XL Check here if first-time participant ☐ if address has changed ☐

Registration fee includes race entry, bus to and from race; t-shirt, refreshments, awards & raffle entry. **Pre-Registration: Regular entry: \$25; Students or Division 47 members, \$20. Convention site registration: \$30.**

If you are an APA member and wish to apply for Division 47 membership with this entry, check below. Include \$15 for membership fee for Division 47. If you join Division 47, your registration fee will be reduced. I wish to apply for Division 47 membership. ☐

APA Status: Member ☐ Fellow ☐ Assoc ☐ Student Affiliate ☐ APA Membership # \_\_\_\_\_

WAIVER: I assume all risks associated with running in this event including, but not limited to: falls, contact with other participants, the effects of the weather, including high heat and/or humidity, traffic, and the conditions of the road, all such risks being known and appreciated by me. Having read this waiver and knowing these facts and in consideration of your accepting my entry, I, for myself and anyone entitled to act on my behalf, waive and release the Running Psychologists, Division 47 and the American Psychological Association, the City of Toronto, and Marathon Dynamics, Inc., subcontractors, sponsors, and volunteers, and their respective representatives and successors, from any and all claims or liabilities of any kind arising out of my participation in the APA 5k Ray's Race and Walk event on Saturday, August 8, 2009 at Coronation Park, even though that liability may arise out of negligence or carelessness on the part of the persons named in this waiver. I grant permission to all of the foregoing to use any photographs, motion pictures and recording or any other record of this event for any legitimate purpose. I HAVE READ THE ABOVE RELEASE AND UNDERSTAND THAT I AM ENTERING THIS EVENT AT MY OWN RISK.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Guardian must sign if applicant is under age 18)

- **Pre-registration is strongly recommended. T-shirts guaranteed only to pre-registrants.**

Check, payable to **Running Psychologists**, must be received by August 1st, 2009 Circle amounts enclosed:

Mail Registration received by 8/1/09 \$25.00 Division 47 Members or Student \$20.00

Division 47 Membership Fee (Add'l)-For APA members \$24.00 Division 47 Fee Student members (Add'l) \$10.00

Convention Site Registration \$30.00

Total Amount enclosed \_\_\_\_\_

Send to: Janet Cain, PhD, Treasurer, Running Psychologists; 935 Trancas St., 1-B, Napa, CA, 95476

Questions? Email: Lucinda Seares-Monica, PsyD, at [psydmd@optonline.net](mailto:psydmd@optonline.net); or Janet Cain, PhD, at [drjcain@earthlink.net](mailto:drjcain@earthlink.net).

Note: Participants will be able to make a donation to the American Cancer Society or the United States Holocaust Museum in memory of Art Aaronson. Please use a separate check for donations.

# Mission of Division 56

## Trauma Psychology

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

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

### Services to APA and its Membership

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

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

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

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

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

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

**Public Education:** Projects working towards public education.

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

### Membership Benefits

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

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

### APA Membership Status

- |                                    |      |  |      |
|------------------------------------|------|--|------|
| <input type="checkbox"/> Member    | \$45 | <input type="checkbox"/> Professional Affiliate      | \$45 |
| <input type="checkbox"/> Fellow    | \$45 | <input type="checkbox"/> Student Affiliate           | \$10 |
| <input type="checkbox"/> Associate | \$45 | (or \$30 with new APA Division journal)              |      |
|                                    |      | <input type="checkbox"/> APAGS (first year students) | Free |
|                                    |      | (or \$20 with new APA Division journal)              |      |

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Are you an APA member? ☐ Yes ☐ No      APA Membership No. \_\_\_\_\_

### Method of Payment

- ☐ Check (Make check payable to "Division of Trauma Psychology, APA")
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### Haworth Press/Taylor & Francis Group

To receive these discounts, complete the membership application and join Division 56. Only include the fee for membership on your check or credit card. Division 56 cannot accept payment for your subscription. Call Haworth at 1-800-429-6784 (607-722-5857 outside US/Canada) or order on-line via the links above and provide the code # TPD20 to receive your 30% member discount.

### JOURNALS

Journal of Child & Adolescent Trauma

Journal of Trauma & Dissociation

Journal of Aggression Maltreatment and Trauma (8 issues annually)

Journal of Child Sexual Abuse (6 issues annually)

Journal of Emotional Abuse

Please register online at [www.apa.org/about/division/memapp.html](http://www.apa.org/about/division/memapp.html) or download our brochure at [www.apa.org/division](http://www.apa.org/division). 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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## TRAUMA PSYCHOLOGY NEWSLETTER

An Official Publication of Division 56 of the  
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<u>Authors' Submission Deadline</u>	<u>Issue</u>	<u>Publication Date</u>
September 15, 2009	Fall 2009	October 2009
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April 15, 2010	Spring/Summer 2010	May 2010

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