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DIVISION 56

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NEWSLETTER

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Presidential Voice

Our Collective Visions of the Division's Future

Laura S. Brown, PhD, ABPP

Although when you read this it will be high summer and many of you will be preparing to pack for the APA Convention in San Diego, it's early spring here in the Pacific Northwest as I sit down to write. Spring here is an astonishing cascade of bloom after bloom, with the huge variety of micro-climates that can be found within a few blocks (and a hundred feet of altitude) of my home offering me the range of cherry and apple trees from those still in bud, to those in full bloom, and finally those with their petals drifting like pink snow. The Steller's Jay, which is a deep-blue bird putting the Blue Jays of my Ohio childhood to shame, is making a nest in the spruce outside my window, and random bulb flowers that have somehow made it into the middle of my lawn are poking up. From the mold and decay and damp that is winter in the Northwest (and spring, and fall, and pretty much everything except the time between mid-July and the end of September), exuberant life is springing out everywhere.

Laura S. Brown, PhD, ABPP

The trauma survivors whose experiences we strive to know through our research, heal through our therapies, empower through our policy work, understand through our teaching, are brought powerfully to mind by the Pacific Northwest springtime. I cannot count the number of times that I have had the honor to witness life and growth emerging from the numbness and tangle of fear that are the legacies of trauma exposure. Like the abundant, burgeoning nature that enveloped me on my walk this Sunday morning, so the trauma survivors in my life—my clients, as well as many of my friends

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Important Note to our Members and Readers

Trauma Psychology Newsletter is now solely electronic beginning with our Winter 2010 edition. Download issues of Div 56's *Trauma Psychology Newsletter* at www.apatraumadivison.org.

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Division 56 Responds to the Manchester Grand Hyatt Controversy

Editor's Note: Letter written by Division 56 President, Laura Brown, on behalf of Division 56 Executive Committee.

Dear Dr. Anderson, Dr. Goodheart & the APA Board of Directors:

We write on behalf of the Executive Committee of Division 56, the Division of Trauma Psychology, which voted to take the actions and make the recommendations detailed below. This is in response to the situation created by APA's decision to continue to use the Manchester Grand Hyatt for the 2010 APA Convention despite the direct involvement of its namesake owner in financially supporting Proposition 8, which abolished same-sex marriage in California. We appreciate the good efforts of the Working Group formed by Dr. Goodheart to attempt to find a resolution to this dilemma that would work for most parties, and know that best efforts are being put into finding solutions. While we are aware that plans continue in progress, we would like now to state our concerns and be specific as to where we stand as a division.

Division 56 sees Mr. Manchester's actions as fostering a hostile environment, thus increasing the probability of hate violence against LBGT community members both in San Diego and elsewhere in California. Further, evidence from empirical research suggests that such actions create malevolent risk factors that increase trauma-related problems among the LBGT community who are exposed to violence. Many Division 56 members in fact see Mr. Manchester's actions as a direct form of aggression against the LGBT community and its allies. The mission of Division 56 is to offer "a specifically psychological voice to the interdisciplinary discourse on trauma, blending science, practice, and a commitment to human welfare in our work" thus Division 56 must respond proactively to this concern as it is indirectly and directly tied to concerns about the psychological and physical reality of trauma.

Furthermore, Div 56 fosters the creation of collegial support for professional activities related to traumatic stress. APA's stance in staying with the Manchester Hyatt undermines a collegial supportive learning environment. APA's longstanding history of alliance with the LGBT community means that its continuing association with the Manchester Hyatt, regardless of the realities constraining APA's actions, is a form of relational betrayal to APA's LGBT community and its allies. We believe that Mr. Manchester has violated his contract with APA by not providing an environment in which all APA members can feel safe, and by in fact creating a situation in which many APA members may experience betrayal and traumatization.

In keeping with our mission and purpose, the Division's Executive Committee has adopted the following actions. Division 56's Executive Committee adopted these actions fully understanding that (1) APA signed a contract with the Manchester Grand Hyatt in 2004, and that APA has not to date found a clause in the contract that would allow cancellation without substantial penalties and that; (2) due to this canceling this contract could have financial implications for the Association that APA is not in a position to absorb at this time; and (3) you and the governance Working Group you appointed have asked groups not to boycott the hotel while seeking "a positive approach" to this difficult situation.

Our Division Commitments

Division 56 commits to holding programming and Divisional activities at the 2010 APA Convention but we will not hold any Division 56 business meetings or social events at the Manchester Grand Hyatt. If they are scheduled there, we will cancel the events at the Hyatt and find another venue.

Division 56 supports APA's plans to highlight scientific research and public debate about same-sex marriage at the Convention.

Division 56 offers, to the best of our capability, our resources and support for any sessions and events relating to same-sex marriage, and to programming exploring the traumatizing psychological impacts of political activities such as Proposition 8.

We will notify our members of these decisions and the rationale behind them. Division 56 members will be encouraged to make plans that best fit with their own personal values and needs.

Our Recommendations to APA

We appreciate the work of the APA working groups and understand the difficulties the APA faces in navigating the best course of action. However, we urge the APA to be guided primarily by the values of the field of psychology, and the recently affirmed policy statement that the *"APA shall take a leadership role in opposing all discrimination in legal benefits, rights, and privileges against same-sex couples."*

Furthermore, Division 56 Calls on APA to:

- Make clear to the general membership what negotiations have taken place with the Manchester Grand Hyatt regarding contract modifications or cancellation.
- Aggressively pursue contract modifications with the Manchester Grand Hyatt. Given the concerns that have come to light, Division 56 believes that the APA has an obligation to its members and Divisions to pursue possible legal solutions. Division 56 also believes that the APA will ultimately bring itself more credit, and stronger support of its membership and the public, by making good faith efforts to renegotiate the contract, keeping in mind that fulfilling it will harm some of APA's members.
- Fully respect the decisions of all members and groups to not attend or hold events at the Manchester Grand Hyatt. Specifically, Division 56 requests that the Convention Office of APA refrain from scheduling any Division 56 Convention programming at the Manchester Grand Hyatt, including Division 56 sponsored and co-sponsored addresses, symposia, poster sessions, and other events.
- Place a flyer in the registration packet indicating that Division 56 joins with other groups and divisions to request that individuals and groups attending the convention refrain from using the services of the

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Div. 56 Responds to Manchester Controversy

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Hyatt (e.g. restaurants, room service, health club and other services that can be found elsewhere)

- Arrange and announce an alternative site for the Convention meetings of the APA Council of Representatives. If no alternative site is found, Division 56 will ask its Council representative to stay elsewhere, and will reimburse that individual for food during the Council meetings so that no division member will be forced to spend money at the Manchester Grand Hyatt.
- Have APA public relations staff arrange a press conference at the Convention reiterating APA's stance on same sex marriage rights
- Review the ways APA chooses and writes contracts for hotels and vendors to ensure that they include systematic research about labor practices and stances on issues of social justice. Division 56 suggests that a routine clause be developed and included in all future contracts that will allow APA to cancel without penalty should it discover that a hotel or vendor has violated a core principle of the Association as defined in our policy statements.
- Assiduously adhere to the provisions and spirit of its 2007 policy "Opposing Discriminatory Legislation & Initiatives Aimed at Lesbian, Gay, & Bisexual Persons" in all future conventions, meetings of APA governance groups (including Board of Directors), and other meetings it sponsors. Among other things, this policy commits APA to assume a leadership role in actively opposing discriminatory legislation and initiatives, to consider these factors in making decisions about meetings and contracts, and to promote the physical and psychological safety of its members and staff when holding meetings or engaging in other contractual agreements in states or jurisdictions with public policy that discriminates on the basis of sexual orientation.
- Develop a multi-year plan and commit resources to incorporating issues of social justice, including LGBT rights and marriage equality, in future APA conventions and activities. This is consistent with APA's vision and mission statements adopted by Council in 2009. Division 56 encourages a longer-term view of ways to deal with the issues raised this year and in response to the situation with the Manchester Grand Hyatt. Division 56 members and leadership would be pleased to assist with these future activities.
- Provide regular updates via the Division officer and other listservs about the situation as it develops at the Manchester Grand Hyatt as well as about special APA-sponsored programming and activities at Convention.

To conclude, Division 56 appreciates the efforts to date of the APA leadership and the governance Working Group and knows full well that the APA faces many difficulties in planning for the 2010 Convention. We also believe that there is much to learn and that more can be done, even in the face of possible financial losses, so that APA's actions can better align with the values of the field of psychology, and with APA's own mission, vision, and policies. We hope to hear from you in regard to this letter and our requests at your early convenience.

Calling All Interested Media Reviewers!

Michelle Sherman, PhD

Greetings! My name is Michelle Sherman, and I'm the new Advisory Editor for the Division 56 Media Review section. I'm creating a list of potential reviewers and would be delighted to include you (and/or your student members)!

Why?
Performing a review will:
- Help our Division learn about new resources about trauma
- Provide a great opportunity to collaborate with a student (help build his/her CV!)
- Give you a complimentary copy of a new book on a trauma-related issue

What's the First Step?
Please *e-mail* your contact information to me (Michelle-Sherman@ouhsc.edu). Submitting your name does *not* commit you to doing any particular review—rather, it's simply an expression of interest. Please include your name, mailing address, phone number, and e-mail address.

How Will It Work?
Division 56 members can notify me upon release of their new books they'd like reviewed. Reviewers can suggest a trauma-related book they'd like to review. I will also browse catalogs to find relevant books and will periodically send out requests to our list of reviewers.

Once the book and reviewer are identified, I will contact the publisher and ask them to mail the book directly to you. I will provide you with short and easy guidelines on the newsletter's preferred format for reviews and will be available to provide support/assistance if desired.

If you have any questions, please don't hesitate to contact me. I hope to hear from you! Thank you.

Michelle D. Sherman, PhD
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2010 Division 56 APA Convention Program

APA Annual Convention
San Diego
August 11–15, 2010

Dawn M Hughes, PhD ABPP, and Kate Richmond, PhD
Program Committee Co-Chairs

California…here we come! As Division 56—Trauma Psychology heads into its fourth year of programming at the American Psychological Association's Annual Convention, we are excited to announce that presentations will cover a broad range of innovative trauma research and clinical endeavors. High quality paper, poster, symposia, and workshop submissions grew by 50% this year suggesting increased interest in our Division and the topics we address. The Program Committee benefited enormously from this surge, and even though the reviewers had to work overtime, we were able to prepare a convention program that portrays a broad range of trauma-related topics that represents the mission of the Trauma Psychology Division and our members, and that will also appeal to a diverse audience at the APA Convention. Submission highlights from the Division 56 program include:

Dawn M Hughes, PhD ABPP

Disclosure of Interpersonal Violence-Social Reactions and Adjustment. This symposium, chaired by Dr. Christine Gidycz with Dr. Sarah Ullman as a discussant, will present research using novel methodologies regarding the disclosure of interpersonal violence with a specific emphasis on social reactions and adjustment. Four papers will provide attendees with increased knowledge regarding disclosure of interpersonal violence and offer important implications for developing and implementing college- and community-based programs to inform support providers on how to respond to interpersonal violence disclosure.

Cumulative Effects of Trauma on Health. This symposium is chaired by Dr. Lisa Cromer with Dr. Kathleen Kendall-Tackett as a discussant. Trauma exposure is predictive of myriad mental and physical health problems across the lifespan. Moreover, trauma experienced in developmental years may especially sensitize the body to future stressors. This symposium offers insight into the long term health impacts of trauma as related to cognitions and schemas about the self, world, and others. Using longitudinal, prospective (pre-and post-trauma) as well as cross sectional data, the authors will present data on factors that impact the long term health trajectories of trauma.

Conducting Psychological Evaluations with Survivors of Human Trafficking. Division 56 is pleased to offer this workshop presented by Dr. Elizabeth K Hopper, Dr. Nancy Sidun, and Ms. Michelle Contreras. These presenters will provide detailed explanations of human trafficking, which is a form of modern-day slavery, a violation of a person's fundamental human rights and of their dignity and worth as a human being. Survivors of human trafficking are in need of trauma-informed services. This workshop will assist participants in developing the skills needed to conduct psychological evaluations of survivors of human trafficking.

This year, Division 56 is delighted to have sponsored an **Invited Address** by two distinguished trauma psychologists **—Dr. Jennifer Freyd and Dr. Constance Dalenberg**. Dr. Freyd will present *Disclosing Trauma: Research and Implications* and Dr. Dalenberg will discuss *Trauma Science in the Context of Human Connection: P < .05*.

A highlight of our program this year will be the presidential address by **Dr. Laura Brown**, *Can We Create Social Justice? A Challenge for Trauma Psychologists*. This address will take place on Saturday, August 14h at 4 pm, followed by the Division Business Meeting at 5 pm.

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

One important symposium will provide concrete examples of current social justice intervention and research initiatives taking place around the country that all share a common theme—a focus on serving and empowering marginalized community members who have experienced trauma in their lives. Authors Kate Carroll, Katherine Richmond, Krista Chronister, and Stephanie Schwartz will present in *Social Justice Research and Trauma—Notes From the Field.*

Rethinking Trauma Psychology Training—A Multicultural and International Perspective, a panel led by Dr. Sandra Mattar, will be presented by a group from the International Committee of Division 56-Trauma Psychology. Authors include Pilar Hernandez, Steven Little, Angeleque Akin-Little and Thema Bryant-Davis with Dr. Kathryn Norsworthy serving as discussant. The objective is to increase our understanding of our methods of educating and training future traumatologists in order to make Trauma Psychology a more globally relevant field.

A panel presented by Drs. Lisa Rocchio, Dawn Hughes, and Richard Thompson will present *Ethical and Professional Considerations in Trauma Psychology—Psychotherapy, Forensics, Research*. In this symposium, the authors address common ethical dilemmas encountered in each of these professional settings and participants will acquire techniques for applying relevant principals of the APA ethics code to the resolution of these dilemmas.

In *Examining Postdisaster Recovery Across Time*, Drs. Gilbert Reyes, Susan Opotow and Ryan Kilmer discuss the urgent and timely topic of the social and psychological impact of disasters on communities. This symposium has been designed to include an overview of contemporary disaster research, case studies of recent disasters in the United States, and audience participation.

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Dr. Jennifer Freyd (Chair) along with authors Tuppet Yates, Anne DePrince and Warwick Middleton will present the symposium *Attachment, Trauma, and Oppression: Social Justice, Clinical, and Research Perspectives*. This symposium draws on research and clinical experience to explore the impact of relational trauma and oppression on psychological functioning, particularly within the realm of close attachments with others.

Trauma psychologists have come to recognize that in addition to the negative effects of trauma, survivors often report positive personal changes, referred to as posttraumatic growth (PTG). The symposium *Indicators of Validity in Reports of Posttraumatic Growth*, chaired by Richard Tedeschi with authors Bronwyn Morris, Kelli Triplett, Lisa Butler and Jane Shakespeare-Finch will feature a discussion of this emerging topic. Charles Figley will serve as discussant.

Division 56 is also please to have seven paper panels on the program this year covering a broad range of trauma topics.

Trauma and Violence in Adolescent Populations brings together psychologists who present varying approaches to addressing trauma and violence among our youth. These three papers include Kamela Scott's *Turning Point: Rethinking Violence—An Innovative Collaboration Addressing Adolescent Violence*, Dr. Kendell Coker's presentation *Linking Trauma and Moral Disengagement in African American Inner-City Youth*, and Dr. Courtney Hive's paper entitled *Community-Based Solution for Incarcerated Female Adolescent Victims of Trauma*.

In addition to a symposium addressing the health impact of trauma, we have a paper presentation that examines this topic further entitled *Broad-Reaching Effects of Trauma—Physical Health, Substance Abuse, and Gender Differences*. Alanna Hager will present *Perceived Stress, Coping and the Physical Health of Maltreatment Survivors*, Dr. Seana Golder will address *Victimization, Psychological Distress, and High-Risk Behavior Among Drug-Involved Women* and Dr. Sharon Tang will discuss *Gender Differences in Posttraumatic Stress: Betrayal Trauma and Gender Roles*.

A very interesting paper session is entitled *Trauma and Recovery in International Populations*. Sefa Bulut from Turkey will present a *Three-Year Longitudinal Study of Turkish Children's posttraumatic Symptoms and Subsymptoms After an Earthquake and School Building Collapse*, Dr. Yasmin Farooqi from Pakistan will address *Gender Differences in Anxiety Among Pakistani Survivors of a Bomb Blast*, and Dr. Beth Meyerowitz will discuss *Trauma and Resilience Among Orphaned Survivors of the Rwandan Genocide*.

A paper session entitled *Posttraumatic Stress Disorder and the Military* will bring three presentations in this area. Dr. Terri deRoon-Cassini will present *PTSD, Depression, and Alcohol Use in a Predeployment Military Sample,* Dr. Christopher Weaver will discuss a *Multidisciplinary Model for Training Police: PTSD and Veteran Culture*, and Dr. Heather Sones will explore *Ethnocultural Differences in PTSD and Anger in Hawaiian Island Veterans*.

One important paper session will address *Advances in Trauma Treatment—Keeping Up With The Times*. This session will bring together contemporary treatments and advances in trauma. Dr. Bridget Ross will present *Treating Veterans With PTSD via Telemedicine: Provider Experience and Satisfactio*n, Dr. Lauren Ng will present her paper entitled *Review of Virtual-Reality Exposure for PTSD* and Dr. Jennifer Wortmann will discuss *Resources that Predict Resilience to Posttraumatic Stress Symptoms*.

Emerging Topics in Trauma brings together three diverse areas in trauma. Dr. James Halpern presents *Assisting Disaster Survivors: Are Practitioners Using Evidence-Informed Practice,* Theresa Benson addresses *Heterosexual Men as Targets of Intimate Partner Violence* and Leah Livesey will discuss *Do Nonsexual Motivations Predict Victim Preference in Child Molesters?*

Intergenerational Trauma will showcase three papers in this area of interest. Lotem Giladi will present *Thundering Silence: Communication Styles, Worldviews, and Secondary Traumatization Among Second- and Third-Generation Holocaust Survivors*, Lauren Mai will discuss *Intergenerational Transmission of Historical Trauma Among Vietnamese Americans*, and Dr. Simon Forstmeier will address *Posttraumatic Stress Symptoms and Posttraumatic Growth in Former German Child Soldiers of World War II*.

In addition, the Division 56 convention program will include two poster sessions entitled *Contemporary Issues in Trauma Psychology* and *Trauma and Recovery: Special Populations.* These poster sessions showcase a disparate and diverse range of papers in the field of trauma psychology.

On Friday, August 13th at 8 pm, Division 56 will be hosting our annual *Social Hour*. The Division 56 Awards Ceremony will be held during our Social Hour at which time awardees will be honored. The Social Hour is also an excellent opportunity to meet Division Leadership and your fellow members in a relaxed and inviting setting. All are encouraged to attend.

Rounding out this full program will be events at the *Division 56 Hospitality Suite* which are still in the planning stages. 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 are also planning events especially for Student Members so be sure to check out the suite schedule upon arriving in San Diego! Please plan on visiting 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.

As stated previously, we had many more excellent paper and symposium submissions than we could accept. You can change this by helping us to get more hours on the convention program. The number of convention hours a division receives is determined solely by the number of people who *indicate it as their primary division when registering for convention*. So please, when you do register for APA, **list Division 56 first**, so that next year we'll have more than the minimum number of hours for your excellent work to be showcased.

In looking at the quality and scope of the 2010 American Psychological Association 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, to the many contributors who submitted quality presentation proposals, and to the large and energetic panel of reviewers who, even with their increased workload this year, made our process so much smoother 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 San Diego!*

Graduate Student Scholarships to Be Offered for Teaching the Psychology of Men Continuing Education Program at the APA San Diego Convention

Teaching the Pyschology of Men will be a Continuing Education Program during the APA Convention in San Diego. Seven 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 for the workshop include: James M. O'Neil, PhD, University of Connecticut, Storrs, CT; Christopher Kilmartin, PhD, Mary Washington University, Fredericksburg, VA; Michael Addis, PhD, Clark University, Worcester, MA; and Mark Kiselica, PhD, The College of New Jersey, Ewing, NJ.

Information about the graduate student scholarships, how to apply, criteria for selection, and the deadline date can be obtained by e-mailing Jim O'Neil, Chair, Committee on Teaching the Psychology of Men, Society for the Psychological Study of Men and Masculinity (SPSMM), Division 51 of APA, at: jimoneil1@aol.com.

Registration For APA Continuing Education Programs Begins May 1, 2010: Call 1-800-374-2721, ext. 5991 or register online registration at apa.org/ce.

Calling All Student Members

Rachel Reed, MA

The Student Affairs Committee of Division 56 is working to provide you with student-specific activities at this year's APA Convention in San Diego. Current plans include a student-member meet-and-greet and a speed mentoring event, jointly sponsored with Division 56 Early Career Psychologists. Be on the look out for locations and times. We hope to see you there!

Student members play an important role within the Division. If you're interested in becoming more involved in initiatives with the Student Affairs Committee, please contact Rachel Reed, MA, at rachelreed@optonline.net.

Help Division 56 Earn More Convention Program Hours!

Laura S. Brown, PhD, ABPP
President, APA Division of Trauma Psychology

The only way that Division 56 can get more hours on the convention program is to have our members list Division 56 as their primary division when registering for APA.

So when you register, please list Division 56 as your primary division.

The order in which you list other divisions makes no difference for programming hours, so giving us your #1 listing is a great way to make a difference and create more space for trauma psychology.

Thanks!

ARC Disaster Mental Health Training

American Red Cross disaster mental health training will be offered at the 2010 APA Convention in San Diego the morning of Saturday, August 14th. Division 56's Disaster Relief Committee is co-sponsoring this training along with APA's Disaster Response Network (DRN; http://www.apa.org/practice/programs/drn/index.aspx) and the San Diego Red Cross chapter. Licensed psychologists who are interested in becoming a disaster mental health volunteer are encouraged to attend. The training is a special three-hour version of the ARC Foundations of Disaster Mental Health training that is usually a full-day course. Upon successful completion of this course, participants will receive Red Cross cards that will enable them to register with their home chapters and work as Red Cross disaster mental health volunteers. The DRN program is currently exploring whether APA CEUs will be available for this abbreviated version of the course.

Disaster mental health volunteers engage in a variety of activities that can include: offering assistance to relief workers and survivors; providing post deployment support through their local Red Cross chapter to staff and volunteers; and engaging in disaster preparedness and recovery activities such as teaching courses, participating in planning meetings with a variety of governmental and nongovernmental agencies and educating the public about common reactions to disaster. For more information about being a disaster volunteer, please read "What Do Psychologists Do at Disaster Sites." http://www.apa.org/helpcenter/disaster-site.aspx

To learn more about this training and/or to register, please contact Kate Kelley (kkelley@apa.org; 1-800-374-2723) or Margie Bird (mbird@apa.org; 1-800-374-2723).

Post-Disaster Efforts and Foreign Trauma Psychology Expertise: Reflections After Chile's Earthquake

Gonzalo Bacigalupe, EdD, MPH
University of Massachusetts Boston and University of Deusto, Bilbao

Gonzalo Bacigalupe, EdD, MPH

Early on February 27, Chileans woke up to one of the most powerful earthquakes ever measured in world's history. It was 3:34 a.m. in Chile. It was 1:34 a.m. in my home in Boston, probably a few minutes before I had checked emails and wished good night to some friends via twitter before falling to sleep. Soon after I woke up and picked up my cell phone, I noticed emails asking if my family was OK. I knew immediately that something really wrong must have occurred. Immigrants know well that whenever someone makes inquiries of that sort on the phone or email, it is because some sort of tragedy may be unfolding. My wife and I jumped out of our bed, automatically connected to the internet, and started making phone calls although without success.

For the next 24 hours, we were glued to the news on the net, trying to sift through what was real and what were inferences or just rumors. The CNN coverage was, initially, not very accurate (alarmist at the start, inaccurate towards the end). The New York Times was reporting about Chile with its regional correspondents in Brazil. Their sources were probably the same as I had via my social media following. For the most part, the best coverage was provided by Chilean radios and television that we were able to access via video and radiostream. If the radio or television were spotty, redundancy was created as people all over the country were re-transmitting the news via social media outlets like Twitter and Facebook. It was a true exercise at global citizenship connectivity.

Soon after the first news made it into the mainstream, professional listservs were also buzzing with activity, and my colleagues began having discussions about what they could do. What would APA and the rest of us do to organize members to help Chile? Often, the underlying discourse included the possibility of offering clinical services in situ. Soon after reading these emotional shows of support and solidarity, I wrote a blog entry cautioning clinicians in how decisions are made when disasters occur. My blog entry at www.socialtechnologiesresearch.com provoked a lot of personal and public notes of support on the part of many of my colleagues as well as some Haitians and South Asian peers I have never met. They all expressed their agreement with what I was articulating in that first reflection, their disapproval of offers of help emerging from an emotional reaction rather than a thoughtful organized process. Obviously, some colleagues raised concerns in a different fashion. A few psychologists suggested that I was discouraging post-disaster efforts by mental health providers abroad. I offer these ideas here not to discourage solidarity but to encourage post-disaster aid that is:

- carefully planned,
- informed by the best evidence,
- culturally affirming,
- fully accountable to recipients,
- empowering to all participants, and
- sustainable over time

The earthquake and the tsunami that affected Chile were horrific natural disasters. Sadly, besides several smaller earthquakes, even weeks after, there were compounded

disasters caused by the post-disaster effort and poverty conditions in most of the areas close to the earthquake epicenter. The center-south regions were the most affected, with several coastal towns and villages destroyed by large waves. Considering the devastating force of the earthquake (with an intensity hundreds of times more powerful than Haiti), the government and private organizations reacted well although in several cities, they were slow in providing security. By the end of the week, the media in conjunction with public and private institutions had organized a large donation drive (telethon) that despite having collected a minuscule proportion of what will be needed for reconstruction was a demonstration of unity and collective solidarity with the victims of the disaster. Similar large musical events within and outside Chile fulfilled the same purpose.

Chile is resilient and united, but this is a serious, traumatic, and truly dramatic natural disaster. Personally my direct family is healthy; inside my parents' apartment some things were destroyed, but nothing a Chilean family would not expect once in while. We know earthquakes occur. They were with no water and electricity and a spotty phone connection during that weekend. Close to the epicenter, a cousin's mother in-law died during the earthquake after a wall collapsed while she was sleeping. For several days, we did not know about some of our relatives in Concepcion, but by midweek we heard that they were doing fine. Phones, though, were not available for many days. Being abroad under these circumstances is probably one of the most difficult times an immigrant goes through. We knew we would survive it, but nonetheless, it was, and still is, extremely upsetting. Being a professional or highly educated immigrant living abroad raises another layer of reflections for me too.

At the end of the first day, I share in my blog,

> In my opinion, Chile will not need foreigners to come and try to help us to recover. There are actually plenty of experts there, good inter-governmental cooperation structure, and a general trust in government. There is also an untapped source of resources, a million Chileans abroad. Many of those Chileans are some of the most distinguished experts in disciplines related to post-disaster response, economics, engineering, social welfare, healthcare, communications, global and public health, psychology, etc. Indeed, some of us would humbly consider ourselves part of that list.
>
> We, Chileans and foreign allies, may be asked to become consultants or provide direct services later on. It may be that some decide to jump and volunteer and/or find funding to go there and work on behalf of post-disaster responses. In my opinion, however, Chileans inside the country are the ones to lead and direct others in these efforts. I write this because I already read on list-serves the well-intentioned discussions about how to help my country of origin. It is understandable; a terrible tragedy calls for solidarity. But, attempting to directly go there or direct those efforts may not be the most productive way of addressing Chile's priorities; it may be that it just deals with our own personal need to connect our pain with their pain or simple solidarity. In spite of this, the immediate needs and how to request them should come from the inside and according to their timeline. Right now, for instance, what people need is drinking water and it is needed tomorrow in some areas. No foreign help can provide that. It will be Chileans who will resolve that problem.

At the macro level, my individual reflection was also reflected in the position of the Chilean government as offers for foreign aid began topour in. Chileans needed time to assess what was needed since managing foreign aid can in itself become a burden. In an exchange with the APA International Office, I found out that my stance was in tune with APA policies. The APA (June5, 2008) *Statement on the Role of Psychologists in International Emergencies* (http://www.apa.org/international/resources/emergency-statement.aspx) does not advise psychologists to travel abroad to disaster areas unless they comply with criteria established by the International Rescue Committee: Psychologists should have (i) previous work in emergency settings and outside their own socio-cultural setting; (ii) basic competence in some of the interventions covered in the guidelines; (iii) an understanding of either community psychology or public health principles; (iv) a written invitation from a nation or established international organization to work in the country (v) as invitation to work as part of an organization that is likely to maintain a sustained community presence in the emergency area (IASC, 2007).

Why is this important? We should prevent creating a sort of cultural tourist expert in disaster mentality. Professional organizations should really depend more on the local knowledge in their own members and should also be asking for the countries' assessment of what they need. It is not enough to be an expert in trauma, speak Spanish, and have a month to volunteer at a mental health clinic in Chile to be of help. What can we do then? In my opinion, it would make sense for professional organizations like APA to consider funding of post-disaster projects that are guided by members who may have a deep knowledge of the country suffering the disaster. There are plenty of qualified clinicians who can provide that help in Chile already. A professional organization like APA, for instance, has immigrants from almost every country in the world willing to consult and help the organization to organize its support in the case of mental health disaster assistance with the participation of experts of those countries who are APA members. These experts may not only know something about the subject but also be able to sync their knowledge with the cultural nuances of their own place. They may also be able to assess more accurately the needs that add to what may not be there. They may truly contribute there. Those immigrants could be the core piece of teams or task forces attempting to organize the aid. Funding Chilean experts to assess with their counterparts in Chile the actual needs of the country would probably increase the chances of making an accurate needs assessment. It could also create an intercultural bridge that could inhibit what might be a well-intended but not empowering and often paternalistic form of "trauma tourism." The team could work with its counterparts in the U.S. as well as the representatives of the country or NGOs that have historical connections with the country. These connections should be informed by an orientation that emphasizes resilience and sustainability via a:

- systemic view
- strength-oriented focus
- curious stance
- politically savvy informed assessment

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Post-Disaster Efforts...

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Slovic (2010) suggested the need for connecting emotionally with the victims to truly care. I agree that our emotional connection should mobilize us. Connecting emotionally with the survivors, however, should not be an exercise in overcoming our own vicarious trauma. We should aid countries in post-disaster situations on their behalf. Thus to sustain it, we need to approach with what we know works best in traumatic situations but also realize that most people there will be resilient enough to support their counterparts. An earthquake, despite its overwhelming objectivity, has different meanings for different people. Therefore, our role may be different than the direct support that is automatically called in when we hear about a tragedy like this earthquake.

Cultural competency guidelines developed in the U.S.—SAMHSA or APA—may not be what it is locally considered appropriate or relevant at a particular historical moment. For instance, social class is one of the most powerful experiential dimensions in South America, as strong as race is in the U.S. Its nuances, however, are not necessarily addressed in the frameworks we have embraced in mainstream psychology. Similarly, an added factor is the perception of who the Americans represent for Chileans. Being culturally competent, therefore, will involve spending a lot of time finding out and being affirming, all of which may be in contradiction with the crisis situation requirements. For instance, a few days after the earthquake, Hillary Clinton visited Chile and brought with her 20 satellite phones. Many perceived what seemed like an obvious form of solidarity by the U.S. government as paternalistic and demeaning since the same or even more advanced phones were being sold at many local stores.

These ideas are not necessarily new. APA offers an updated FAQ related to international disasters at www.apa.org/topics/disasters/international-response.aspx#. A database of experts by geographical area is another initiative that members of Division 53 may want to consider joining at www.apa.org/international/governance/cirp/experts.aspx. Besides the volunteer clinical services opportunities, there are many other ways of contributing in post-disaster situations. During the weeks after the disaster, there was a great need for information among teachers, parents, and mental health professionals in Chile. Trauma research and informational materials needed to be selected and translated. It was very important to find reliable and accurate materials and databases that could be recommended to Chileans. To achieve this purpose, we need to become versatile with the use of social media and be aware of the often large variation in literacy. At the local level, as trauma experts, we should speak to the media. Reporters are willing to talk with you when the disaster is on the front page. We should use this as an opportunity to write editorials and letters to the editor, give interviews, and share with the public our relevant trauma research. The time frame for that to happen is very short but we should not wait too long. When providing ongoing support and encouragement to our fellow colleagues abroad, listen and pay attention to the evolving nature of the story without jumping onto "helping." More generally, when we are invited to the clinical arena, I would encourage an emphasis on resilience, the impact of ambiguous loss, and the large variability of experiences as a result of the disaster and post-disaster experience.

Resources for Mental Health Providers in Post-Disaster Contexts

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Landau, J., Mittal, M., & Wieling, E. (2008). Linking human systems: strengthening individuals, families, and communities in the wake of mass trauma. *Journal of Marital and Family Therapy, 34*(2), 193–209.

Petevi, M., Revel, J. P., and Jacobs, G. A. (2001). *Tool for the rapid assessment of mental health needs of refugees, displaced and other populations affected by conflict and post-conflict situations*: *A community-oriented assessment.* Geneva, Switzerland: World Health Organization.

Seynaeve, G., Archer, F., Fisher, J., Lueger-Schuster, B., Rowlands, A., Sellwood, P., Vandevelde, K., & Zigoura, A (2004). International standards and guidelines on education and training for the multi-disciplinary health response to major events that threaten the health status of a community [Electronic version]. *Prehospital and Disaster Medicine, 19*(2).

Somasundaram, D. J., & van de Put, W. A. (2006). Management of trauma in special populations after a disaster. *Journal of Clinical Psychiatry, 67*(Suppl. 2), 64–73.

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Gonzalo Bacigalupe is associate professor at the University of Massachusetts Boston College of Education and Human Development and adjunct research professor with the UMASS Medical School. He is also an adjunct professor with the Master Psychotherapeutic Intervention at the National University at Distance in Spain (UNED).

At the time of this publication he is Ikerbasque Research Professor in the Basque Country at the University of Deusto Department of Psychology, working to initiate research in the areas of family health, immigration, and social technologies. His research has included transnational families and couples, political and family violence, refugees' and immigrants' health and health disparities, and is venturing in the e-health and social technologies arena.

Dr. Bacigalupe was a Senior Fulbright Research Fellow at the Autonomic University of Barcelona in 2004. He is Associate Editor of Family Systems & Health and member of the editorial boards of the Journal of Marital & Family Therapy, and Qualitative Research in Psychology.

He holds a BS and MS Equiv. in Psychology from the Catholic University of Chile (1986), an EdD Counseling Psychology (Family Therapy) from the University of Massachusetts Amherst (1995), and an MPH from Harvard University (2007).

He can be found at @bacigalupe or @healthglobal. More info can be found at www.bacigalupe.wordpress.com

Call for Papers!

Special Issue on Trauma Education and Training, *Psychological Trauma: Theory, Research, Practice, and Policy*

Guest Editors: Anne P. DePrince and Elana Newman

Psychological Trauma: Theory, Research, Practice, and Policy, the APA Division 56 peer-reviewed journal, invites submissions of empirical, theoretical, or review articles that focus on teaching about trauma. In particular, manuscripts for this Special Issue should provide a vehicle for sharing theory and research on trauma education practices, thus facilitating effective dissemination of trauma-related research and clinical information.

Manuscripts can focus on trauma education at any educational level (e.g., primary, secondary, graduate; professionals), across diverse audiences (e.g., education of students, medical professionals, journalists, lay public, etc.), and across different modalities (in person, learning collaboratives and communities, Internet, video, mp3). Further, both theoretical/review and empirical articles will be considered. Theoretical/review articles should provide analysis and discussion of pedagogy for trauma education in such depth to warrant a publication in the journal versus other venues (e.g., Division 56 Newsletter). For example, a successful submission might provide a critical analysis of best practices for educating mental health professionals about psychological trauma with recommendations for future theory, research, practice and policy. Empirical articles should provide new data that evaluate education needs and/or practices; given the state of the art, both research and service evaluation. For example, a successful manuscript might describe data on trauma education needs among predoctoral interns; outcomes on learning communities, data evaluating the effectiveness of teaching strategies in trauma courses at the undergraduate level or statistics on the utility of an online course for professionals.

Manuscripts must be consistent with APA's usual submission guidelines, as noted on webpage http://www.apa.org/journals/authors/all-instructions.html, as well as those specific to Psychological Trauma, available at http://www.apa.org/journals/tra/submission.html. Papers that do not follow guidelines may be returned without review. Papers should be no more than 25–30 pages in length, inclusive of tables, references, and figures.

Submit papers: Papers should be submitted through the Manuscript Submission Portal (see http://www.apa.org/journals/tra/submission.html for a link to the Portal). In the cover letter, you must indicate that the manuscript submission is for the Special Issue on teaching.

To be eligible for inclusion in the Special Issue, papers must be submitted by August 1, 2010. Early submissions are encouraged. Papers that do not meet the deadline will be considered as "regular" submissions to this journal.

Save the Date!

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

Topher Collier, PsyD

Fall 2010 *TPN*

The *Trauma Psychology Newsletter* is accepting articles for the Fall 2010 issue. The deadline for submissions is **September 15, 2010**. 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@mac.com. Please also include a brief author bio and photograph (jpg or tiff formats only).

EMDR Therapy: Adaptive Information Processing, Clinical Applications and Research Recommendations

Editor's Note: This is an invited article from Division 56 2009 Award Recipient Dr. Francine Shapiro.

Francine Shapiro, PhD
Mental Research Institute, Palo Alto, CA

I want to begin by thanking the Division for honoring me with the 2009 *Award for Outstanding Contributions to Practice in Trauma Psychology*. I was very touched to have received the award in the 20th year since the publication of my first article in the *Journal of Traumatic Stress* in 1989. I also appreciate this invitation to provide an update on some of the recent advances in eye movement desensitization and reprocessing (EMDR) practice that are relevant to the Division, along with a clarification of its current procedures and theoretical underpinnings. For instance, due in part to my first publication, which described "EMD" solely in terms of desensitization with repeated return to the target memory, many in the field are unaware that, as EMDR, it is no longer simply an exposure treatment. In fact, with the accent on "reprocessing," EMDR pays only occasional attention to the initial target and, importantly, includes the facilitation of an association process that actually *contradicts* most of the tenets of current exposure therapies. Therefore, I will also take this opportunity to explain some of the differences between these treatment orientations, since this distinction points the way to additional clinical applications and research opportunities.

Francine Shapiro, PhD

As you may know, EMDR is a psychotherapeutic approach that has proven effective for the treatment of trauma by approximately 20 randomized controlled trials (RCT) entailing comparisons with both pharmaceuticals (van der Kolk et al., 2007) and other treatments, including seven comparisons with exposure-based therapies (see Bisson & Andrew, 2007; see also http://www.emdrhap.org/emdr_info/researchandresources.php). Based on this evidence, EMDR has been recommended as a first-line trauma treatment, along with trauma-focused cognitive behavioral therapies (CBT), in the international practice guidelines of numerous organizations, including the American Psychiatric Association (2004). Over the past 20 years, we happily have discovered that it is possible to expand EMDR applications to successfully address a wide range of a clinical complaints related to adverse life situations. In addition, research has identified a variety of physiological changes that have important implications for the field.

Neurophysiological Research

Over the past decade, the rapid treatment effects of EMDR have provided neuro-physiological and clinical researchers with a "window into the brain," as seen in over a dozen neurobiological studies that demonstrated pre-to-post processing changes supporting the efficacy of EMDR (e.g., Kowal, 2005; Lamprecht et al., 2004; Lansing, Amen, Hanks, & Rudy, 2005; Levin, Lazrove, & van der Kolk, 1999; Ohtani et al., 2009; Propper, Pierce, Geisler, Christman, & Bellorado, 2007). One such study (Bossini, Fagiolini, & Castrogiovanni, in preparation) revealed that the deficit in hippocampal volume in PTSD patients relative to normal controls was reduced by EMDR treatment. Specifically, it was demonstrated that 8 sessions of EMDR memory processing were correlated with a 6% increase in hippocampal volume in these participants, with effects maintained at one-year follow-up. Notably, the first PTSD patient evaluated (Bossini, Fagiolini, & Castrogiovanni, 2007) had left hippocampal atrophy at the beginning of the study and responded to EMDR treatment with a growth of 10% in the right hippocampus and 12% in the left. Given that the patient was the son of a bipolar mother and the clear concern that adverse life experiences during childhood can have lasting cognitive and behavioral effects (Felliti et al., 1998; Obradovic´ et al., 2010), such outcomes are very promising and indicate the need for further research to investigate not only the mechanisms underlying EMDR treatment, but those of brain neuro-plasticity in general. EMDR has a particular advantage in this kind of research in that it can be applied on *consecutive days*. Unlike CBT trauma therapies, which necessitate 1-2 hours of daily homework, EMDR effects are achieved within-session only (see Rothbaum, Astin, & Marsteller, 2005; Shapiro, 2001). Therefore, EMDR treatment may be concluded in a matter of days, rather than months, reducing the confounding effects of the mere passage of time.

Comparison with Exposure Therapies

While EMDR has been extensively validated as effective, like other forms of psychotherapy, the underlying mechanisms of action are still under investigation. A variety of factors are worthy of attention, and additional comparisons with exposure therapies are warranted to ascertain both commonalities and differences in the search for neurophysiological concomitants of both treatment and change. For instance, because it is generally posited that exposure therapies for trauma are facilitated through habituation or extinction, their procedures are designed to ensure that the patients maintain unwavering attention to the targeted memory (Foa, Huppert, & Cahill, 2006; Marks et al., 1998). In contrast, the EMDR procedures entail only short and occasional attention directed to an initial targeted memory and an associative process, with client responses that "distance" rather than "relive" the memory (Lee & Drummond, 2008; Lee, Taylor, & Drummond, 2006). According to most exposure theorists, these procedures would be expected to sensitize patients and increase their symptoms (Marks et al., 1998; see also Craske, Herman, & Vansteenwegen, 2006). In fact, some of the very processes identified by research as concomitants of the sets of eye movements used in EMDR would be considered "avoidance" in the context of prolonged exposure therapies. An example is episodic retrieval (Christman, Garvey, Propper, & Phaneuf,

2003), which in clinical practice is represented by the patient's automatic associations to thoughts and memories other than the targeted event. As noted by Rogers & Silver, 2002: "While it is possible to explain the accessing of further negative details of the trauma and other forgotten traumatic experiences as a form of state-dependent recall, during EMDR clients also generate strings of associations to positive material as well as negative. In fact, what happens during EMDR more closely resembles assimilation and accommodation than it does habituation. . . This learning or information processing is not extinguishing of negative affect through repeated and maintained exposure" (p.54). The fact that treatments as different as EMDR and prolonged exposure therapy can have comparable salutary effects with overt symptoms of PTSD gives the field an excellent opportunity to investigate various mechanisms of action, and invites comparisons in treatment outcomes such as relapse, generalization, post-traumatic growth, resilience, etc. (Solomon & Shapiro, in press)

Bilateral Stimulation

EMDR therapy consists of a variety of protocols and procedures (Shapiro, 2001) that include the repeated use of bilateral stimulation (i.e., eye movements, tactile taps, or auditory tones), of which the eye movements have received the greatest attention by memory researchers. Unfortunately, the results of earlier component analyses with PTSD patients were confounded by the use of inappropriate populations, insufficient treatment dose, questionable fidelity and low power (Chemtob, Tolin, van der Kolk, & Pitman, 2000; see also Perkins & Rouanzoin, 2002). However, more recently, over a dozen randomized studies investigating underlying mechanisms such as the orienting response and working memory have found that the eye movements facilitate memory retrieval and attentional flexibility, as well as reduce vividness of mental imagery, and negative emotions associated with autobiographical memories (e.g., Andrade, Kavanagh, & Baddeley, 1997; Barrowcliff, Gray, Freeman, & MacCulloch, 2004; Gunter, & Bodner, 2008; Kuiken, Bears, Miall, & Smith, 2001–2002; Parker, Buckley, & Dagnall, 2009; Van den Hout, Muris, Salemink, & Kindt, 2001) as well as future fears (Engelhard, van den Hout, Janssen, & van der Beek, in press), all of which are readily discernable during the EMDR treatment process. Additional studies have demonstrated the onset of a parasympathetic response upon elicitation of the eye movements (Elofsson, von Scheele, Theorell, & Sondergaard, 2008; Sack, Lempa, Steinmetz, Lamprecht, & Hofmann, 2008).

While some behavior therapists may wonder whether the eye movements might serve as a type of distracter, which has been shown to have some benefits in the CBT treatment of phobias (Oliver & Page, 2003), Foa and colleagues have posited that distraction is indicated for phobics, but not other anxiety disorders (Foa, Huppert, & Cahill, 2006). In addition, a recent study of trauma patients comparing the effects of eye movements, counting and exposure indicated that " . . . the counting task had no effect on vividness compared to exposure only, suggesting that the eye-movement task had a specific effect rather than serving as a general distractor" (Lilley et al., 2009, p. 317). As we await the results of further randomized trials with PTSD patients, we hope they will meet the criteria elucidated in the 2000 ISTSS Practice Guidelines, which included "carefully defined control conditions, establishing high levels of fidelity, and incorporating large numbers of patients drawn from treatment responsive populations" (Chemtob et al., 2000, p. 151–52).

Adaptive Information Processing Model

EMDR is guided by the Adaptive Information Processing (AIP) model (Shapiro, 1995, 2001, 2007), which posits that, with the exception of organic insult or deficits, chronic dysfunctional perceptions, responses, attitudes, self-concept, and personality traits are all symptoms of unprocessed memories. According to this model, a high level of disturbance at the time of an event causes the information processing system to fail to properly assimilate the experience into the normal, comprehensive memory networks. As a result, these unprocessed memories are stored in isolation, and contain the affects, thoughts, sensations, and behavioral responses that were encoded at the time of the event. The primary aim of EMDR treatment is to target the dysfunctional memories that are triggered by the client's current life conditions, and transmute them into functional ones by harnessing the natural neural processes of memory consolidation (Shapiro, 2001; Solomon & Shapiro, 2008). This means that, unlike CBT, there is no deliberate manipulation of beliefs and behaviors, but rather the fostering of a naturalistic associative process that allows the appropriate connections to be made internally to adaptive information that already exists within the patient's extant memory networks. These changes are manifested by a rapid and spontaneous emergence of insights, changes in affect, imagery, beliefs and physical sensation.

It is posited that EMDR engages the same processes that occur in rapid eye movement sleep (Stickgold, 2002, 2008). These reprocessed memories are then functionally stored and successfully integrated with similar experiences. The end result is an assimilation of the new information into extant memory structures in semantic rather than implicit or episodic memory, which then allows individuals to respond adaptively to current life circumstances. As previously mentioned, unlike CBT information processing models, AIP/EMDR guides an associative memory process whereby clusters of memories are treated simultaneously, with generalization to both current and future events. As such, EMDR processing contrasts with exposure therapies that function by means of habituation or extinction. The latter is ". . . conceptualized as the development of a second context-specific inhibitory association that, in contrast to fear acquisition, does not easily generalize to new contexts" (Craske et al., 2006, p. 12). In contrast, it is argued that EMDR involves the process of assimilation and reconsolidation (see Solomon & Shapiro, 2008) by which the original memory is altered and restored (Suzuki et al., 2004). Consequently, EMDR treatment addresses a wide range of experiential contributors (e.g., not limited to those involving fear and anxiety), and can be seen to form the basis of many clinical complaints.

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EMDR Therapy

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Case Conceptualization

EMDR is an 8-phase approach (see Table 1) involving a thorough history taking that evaluates the entire clinical picture in order to identify the adverse life experiences that appear to be the basis of pathology. This phase includes a Criterion A trauma assessment and attention to the important areas documented in the Adverse Childhood Events (ACE) Study (Felliti et al., 1998). However, a wider range of disturbing events can also set the foundation for dysfunction, including exposure in their family of origin to marital conflict, negative/anger expressiveness, negative parenting styles, as well as other damaging childhood experiences, including school/peer humiliations, failures, etc. (see Obradovic´, Bush, Stamperdahl, Adler & Boyce, 2010; Shapiro, 1995, 2001, 2007). A thorough assessment during history taking also identifies the specific symptom patterns, including negative beliefs (e.g., lack of self-esteem, safety and efficacy), chronic disturbing emotions (e.g., shame, guilt, anger, sadness, fear), physical sensations, and uncontrollable behaviors. Using various prescribed procedures, all of these symptoms are traced back to the earliest memories encoding these experiences, as these appear to be the basis of the pathology. A thorough assessment and subsequent treatment during the reprocessing phases address the full clinical picture by (a) accessing and processing the memories related to the dysfunction, (b) identifying and processing the current conditions that trigger disturbances, and (c) incorporating memory templates for appropriate future action, including those that address developmental deficits, useful skills, and behaviors necessary for optimal functioning. Specific techniques are taught during the preparation phase to prepare for processing and to return the client to equilibrium at the close of each session, with instructions to maintain between-session stabilization. The reevaluation phase re-accesses the treated memory to ascertain new perspectives that may need to be addressed through information or additional processing, and guides the clinician through the stages of the pertinent protocols. Systematic evaluation has indicated that a wide variety of clinical complaints are caused or exacerbated by unprocessed memories (see

Table 1. Overview of EMDR Treatment

Phase	Purpose	Procedures
Client History	• Obtain background information • Identify suitability for EMDR treatment • Identify processing targets from positive and negative events in client's life	• Standard history-taking questionnaires and diagnostic psychometrics • Review of criteria and resources • Questions regarding (1) past events that have laid the groundwork for the pathology, (2) current triggers, and (3) future needs
Preparation	• Prepare appropriate clients for EMDR processing of targets • Stabilize and increase access to positive affects	• Education regarding the symptom picture • Metaphors and techniques that foster stabilization and a sense of personal self-mastery and control
Assessment	• Access the target for EMDR processing by stimulating primary aspects of the memory	• Elicit the image, negative belief currently held, desired positive belief, current emotion, and physical sensation, and baseline measures
Desensitization	• Process experiences and triggers toward an adaptive resolution (0 SUD level) • Fully process all channels to allow a complete assimilation of memories • Incorporate templates for positive experiences	• Process past, present, future • Standardized EMDR protocols that allow the spontaneous emergence of insights, emotions, physical sensations and other memories • "Cognitive Interweave" to open blocked processing by elicitation of more adaptive information
Installation	• Increase connections to positive cognitive networks • Increase generalization effects within associated memories	• Identify the best positive cognition (initial or emergent) • Enhance the validity of the desired positive belief to a 7 VOC
Body Scan	• Complete processing of any residual disturbance associated with the target	• Concentration on and processing of any residual physical sensations
Closure	• Ensure client stability at the completion of an EMDR session and between sessions	• Use of guided imagery or self control techniques if needed • Briefing regarding expectations and behavioral reports between sessions
Reevaluation	• Evaluation of treatment effects • Ensure comprehensive processing over time	• Explore what has emerged since last session • Re-access memory from last session • Evaluation of integration within larger social system

(Shapiro, 2005)

Shapiro, 2001; http://www.emdrhap.org/emdr_info/PDF/EMDRClinicalapplications2009.pdf). Hence, EMDR treatment directly addresses the physiologically stored memory networks that underlie both psychological problems and mental health.

Clinical Applications

During EMDR treatment sessions, the rapid shifts in cognition, affect and somatic response reveal consistent patterns of internal associative memory processes. In a typical EMDR session, the clinician will routinely observe that each new set of bilateral stimulation is accompanied by the rapid appearance and alteration of emotions, insights, sensations, and memories, together with an accompanying reduction of subjective distress (for session transcripts see Shapiro, 2002; Shapiro & Forrest, 1997). Clients not only undergo reduced emotional disturbance (and other overt symptoms), but, in addition, a comprehensive psychological reorganization of affect regulation and personality traits may be observed (e.g., Brown & Shapiro, 2006; Levin, Lazrove, & van der Kolk, 1999; Manfield & Shapiro, 2003). The successful outcome of the processing of pivotal childhood memories is both the elimination of the clinical diagnosis, and a positive change in interpersonal dynamics (e.g., Brown & Shapiro, 2006; Protinsky, Sparks, & Flemke, 2001; Shapiro, Kaslow & Maxfield, 2007). In cases of complex PTSD, characterized by childhood onset trauma and serial abuse/neglect, the EMDR/AIP case conceptualization views the relative paucity of personal resources as a lack of positive/adaptive memory networks. In order to facilitate processing, Skill Training in Affect Regulation (Cloitre, Cohen, & Koenen, 2006) and Dialectic Behavior Therapy (Linehan, 1993) can be successful integrated with EMDR treatment, along with a sensitive use of the therapeutic relationship, to increase stabilization and access to positive states. The same is true for the use of Seeking Safety (Najavits, 2001) in the EMDR treatment of substance abuse (Brown & Gilman, 2005; Brown, Gilman, & Goodman, 2010; see also Zweben & Yeary, 2006). At that point, the three-pronged protocol is implemented (i.e., processing of past memories, current triggers, and templates for appropriate future action), which further assists in affect regulation and stabilization, as processing eliminates the "volcano" of dysfunctional affects encoded in the targeted memories.

In addition to the insights engendered during targeted memory processing, EMDR treatment facilitates rapid learning, as the range of developmental deficits caused by the isolation/symptoms/lack of modeling/socialization is addressed through the encoding of new memory templates that incorporate skills and behaviors related to the client's poor personal and social development (Shapiro, 2001). Further, since the effects of EMDR are achieved within a given session, with no need for homework, treatment can occur on consecutive days. This attribute can be of great benefit for highly disturbed clients because memory processing can be completed rapidly, alleviating suffering within days rather than weeks. It also appears to increase and maintain stability, and decreases the likelihood of attrition. Since with EMDR it is not necessary to give verbal descriptions of the traumatic experiences, the shame and guilt generally experienced by these clients can be processed without the pressure to divulge details of the event. As previously mentioned, EMDR does not involve a "reliving" of the event, but rather instructions to simply notice whatever associations automatically arise.

Chronic pain can also be successfully treated with EMDR (Ray & Zbik, 2001), as predicted by the AIP model, which posits that dysfunctionally stored unprocessed memories contain within them the sensations stored at the time of the event. For instance, 80% of patients in an aggregate of four independent evaluations experienced a substantial reduction or elimination of their phantom limb pain subsequent to the processing of pivotal memories, simultaneously with depression and trauma symptoms, effects that were maintained for as long as one-year follow-up (de Roos et al., in press; Russell, 2008a; Schneider et al., 2007, 2008; Wilensky, 2007). EMDR has also been used to successfully treat a subset of child molesters who had themselves been victimized as children. Sex Offender Treatment and Evaluation Project (SOTEP) longitudinal study (Marques,Wiederanders, Day, Nelson, & van Ommeren, 2005) reported that arousal to children was the only in-treatment measure to differentiate recidivism. Consistent with AIP predictions regarding the effects of EMDR processing on perspectives, affects and sensations encoded at the time of the event, it was shown by Ricci, Clayton, & Shapiro (2006) that the addition of six EMDR memory-processing sessions to a standard CBT program resulted in " . . . consistent and sustained decline in deviant sexual arousal compared to the control condition. As measured by the [Sexual Offender Treatment Rating Scale], decrease in arousal was also correlated with a decrease in sexual thoughts, increased motivation for treatment, and increased victim empathy" (p. 538). Ninety percent of the perpetrators treated were able to accept the appropriate responsibility for their actions, recognize the harm they had done to their own victims, and demonstrated sustained reduced arousal to children, as measured by the plethysmograph at post-test and one year follow-up. All of the aforementioned findings have important clinical implications and are in need of further rigorous research.

The preceding results support the view that EMDR processing eliminates the emotions, cognitions and physical sensations associated with dysfunctional memories, thereby changing the client's experience in the present. As such, AIP/EMDR views pathological responses as symptoms, whose cause is the stored unprocessed memories that contain the perceptions encoded at the time of the original disturbing event. The clinical applications of direct memory processing are not limited to anxiety disorders. Indeed, processing the appropriate memories can also serve to eliminate depression, whether caused by critical events consistent with the diagnosis of PTSD (e.g., van der Kolk et al., 2007) or other, more ubiquitous kinds of distressing life experiences, such as parental arguments, divorce and humiliation (e.g., Bae, Kim, & Park, 2008). Likewise, processing pivotal memories has been shown to normalize "attachment style" in both adults and children (e.g., Madrid, Skolek, & Shapiro, 2006; Wesselman, Davidson, & Potter, in press; Wesselman & Potter, 2009), with a concomitant alteration of automatic behavioral responses that indicates a cessation of the inter-generational transfer of dysfunction. Clearly, these salutary effects have many major implications for social policy and should be the subject of additional research.

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Combat Veterans

Given increasing pressure on the treatment delivery system for our combat veterans and the complexity of treatment due, in part, to the "warrior mentality," it would be useful to consider the advantages of EMDR. As noted in the American Psychiatric Association Practice Guidelines (2004, p. 18), in EMDR "traumatic material need not be verbalized; instead, patients are directed to think about their traumatic experiences without having to discuss them." Given the reluctance of many combat veterans to divulge the details of their experiences, this dynamic has important implications for the willingness to initiate treatment, reduced attrition and therapeutic gains. This lack of verbalization may be one of the factors, along with the relatively rapid decline of distress within the first session (Elofsson et al., 2008; Ironson, Freund, Strauss, & Williams, 2002; Rogers et al., 1999; Sack et al., 2008; Wilson, Silver, Covi & Foster, 1996), that is responsible for the high remission and low dropout rate noted in this population when a full course (e.g., 12 sessions) of EMDR is implemented (Carlson et al., 1998; Russell, Silver, Rogers, & Darnell, 2007; Silver, Rogers, & Russell, 2008; also see Chemtob et al., 2000 for a review). In addition, since EMDR can be administered on consecutive days, it may be particularly suited for the alleviation of symptoms on the battlefront (see Russell, 2006; Wesson & Gould, 2009), as well as for in-patient treatment (Silver, Brooks, & Obenchain, 1995). Further, the prevalent somatic and chronic pain problems experienced by combat veterans and the evidence that EMDR can successfully treat phantom limb pain (see also Ray & Zbik, 2001) and alleviate war-related, medically unexplained symptoms (Russell, 2008a,b), demonstrate its utility for this population. EMDR also has distinct benefits for combat veterans with multiple complaints, given the fact that it can simultaneously address PTSD, depression, pain, and sleep disturbance (Raboni, Tufik, & Suchecki, 2006; Silver, Rogers, & Russell, 2008). In sum, EMDR can be highly useful for the treatment of combat veterans, and further research should be carried out to compare it with other extant treatments for this population in regard to these clinical complaints.

Disaster Response

The present clinical findings have important implications for emergency preparedness. For instance, EMDR has been implemented on consecutive days post disaster in Europe, Latin America and Asia, using both individual and group protocols (e.g., Aduriz, Bluthgen, & Knopfler, 2009; Fernandez, Gallinari, & Lorenzetti, 2004; Jarero, Artigas, & Hartung, 2006; see also Konuk et al., 2006; Zaghrout-Hodali, Alissa, & Dodgson, 2008). The published evaluations have shown that teams of clinicians can successfully treat traumatized populations in a few days rather than weeks or months. The EMDR Humanitarian Assistance Programs (HAP) (http://www.emdrhap.org), a non-profit organization dedicated to the alleviation of suffering worldwide currently coordinates the delivery of treatment and pro bono clinical training in areas of need. Given the clear lessons of history that violence begets violence, one major goal of HAP is to address the trauma caused by both human-made and natural disasters, to help facilitate peace-making efforts and prevent the intergenerational transfer of traumatic effects. For the same reason, HAP offers low-cost clinical trainings to non-profit agencies addressing the needs of underserved populations within the US, and provides post-disaster pro-bono treatment through the Trauma Response Network (e.g., Silver, Rogers, Knipe, & Colelli, 2005). As I mentioned last year, I am happy to offer the services of HAP for any joint community or post-disaster outreach planned by the Division.

Conclusion

Although EMDR reduces the overt symptoms of a variety of clinical complaints, a primary goal is to alter the underlying conditions that generate the dysfunctional response in the present and bring the client to an adaptive state of mental health. This is achieved by making memory networks and information processing the primary foci of both case conceptualization and treatment practice. The Adaptive Information Processing model that guides EMDR practices offers a reconceptualizaton of the impact of stored memories across the spectrum of clinical complaints, expanding assessment and treatment to the full range of adverse experiences. The rapid and consistent treatment effects that result from EMDR processing of the experiential contributors to dysfunction can help to expand our understanding and treatment of various disorders, and allow researchers to evaluate the psychological and neurophysiological concomitants of pathology, treatment, recovery and health. I am happy to assist researchers interested in RCT in any way I can. We are all searching for the best ways to serve those in need. I share the views of those in this Division who believe this can best be done through collaboration, integrative practice, and rigorous evaluation.

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Report on National Partnership to End Interpersonal Violence

Sylvia A. Marotta, PhD, ABPP
Division 56 Representative to the NPEIV

The National Partnership to End Interpersonal Violence (NPEIV) held its second Summit on Violence and Abuse in Relationships on February 24–26, 2010, in Dallas, Texas. The theme *was Interpersonal Violence and Abuse across the Lifespan: Forging a Shared Agenda*. A one day think tank preceded the summit. The list of partners sponsoring summits and think tanks on violence prevention continues to grow, approaching 200 agencies, organizations, and advocacy groups. The Summit was opened by the three facilitators, Alan Kazdin, Professor, Yale University; Jackie White, Professor, University of North Carolina at Greensboro; and Robert Geffner, President, IVAT at Alliant International University, who have shaped the partnership since its inception in 2007. The mission of NPEIV has evolved through their leadership and the work of an active steering committee of approximately 40 people representing partner organizations. The current mission is to apply the latest science, best practices, and policy information to the prevention of interpersonal violence. In addition to prevention, the NPEIV is committed to providing a model of healthy relationships through a variety of mechanisms, some of which are described below. The working groups charged with these mechanisms are italicized.

Sylvia A. Marotta, PhD, ABPP

At the time of this writing, the first *public awareness* initiative of the partnership is in the planning stages, an effort entitled "Freeze to Stop the Silence." Using web technology, participants will freeze in place at locations around the country on April 30 with the simple message of stopping child sexual abuse. The event was organized by the *public relations* working group of the NPEIV. In the next few months, a public relations firm will be consulted on ways to engage the public using social networking and other media. The working group plans to engage marketing students in colleges and universities, in designing effective ways of reaching out to lay audiences.

On the *research* front, special issues in journals focused on interpersonal violence will have a cross-disciplinary focus. A two-volume series, *Violence Against Women and Children: Consensus, Critical Analysis, and Emergent Priorities*, co-edited by Jackie White, Mary Koss, and Alan Kazdin, is in press and should be out in the fall.

The *dissemination and translation* working group is writing to editors of leading journals asking that discussion sections in violence related journals include research and policy implications in their instructions to authors. The working group sponsored a workshop at the Dallas Summit on the intersection of violence and drug abuse. As has been the practice since the partnership was first initiated in 2007, national meetings of sponsoring organizations have implemented themed tracks or individual sessions with a focus on violence prevention. Working groups will continue this practice in September at the Institute for Violence Abuse and Trauma meeting in San Diego in September.

As a way of identifying internal needs and outreach to the national population, surveys are being designed by several of the working groups to identify best practices in the various disciplines engaged with interpersonal violence intervention and prevention. Survey data will also provide a focus for reaching out to those organizations and entities with a public policy interest. A long-term goal here is to provide common language, research based policy linkages, and a reformulation of what is considered normative behavior by the public when it comes to healthy relationships.

In these difficult economic times, perhaps the biggest challenge facing the NPEIV partners is how to develop a master funding plan to provide resources to each of the working groups. Seed money has been provided by the partnerships, and in kind support for travel and meetings by participants, but an overarching infrastructure of support needs to be secured by the working groups on *funding and on development* for NPEIV.

NPEIV partners are committed to ensuring that *training and mentoring* in the area of interpersonal violence prevention is intentional at all levels. Some of the questions being addressed by the working group are: (a) Is there a need for a certification or a minor at the undergraduate level on issues related to a lifespan approach to interpersonal violence prevention? (b) Would a clearinghouse of resources on the NPEIV website be useful in training professionals? (c) What are advantages and disadvantages of having graduate and undergraduate level courses on interpersonal violence in various types of public colleges and universities across the country? Some creative innovations were discussed, such as using alcohol taxes to fund public university courses on the intersection between violence and alcohol abuse.

The working groups will meet electronically between now and the September meeting in San Diego. For more information about the various projects, visit the website at http://www.uncg.edu/psy/npeiv/

With Appreciation

Manuscripts for *TPN* were reviewed by members of the Editorial Board.
We thank them for this important service.

From Science to Practice and from Practice to Science in Psychology: Facial Mirror Therapy

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Abstract

Psychological practice is scientifically informed, but both professionals and the media question to what degree this takes place, and whether the profession needs to improve its approach. This paper gives three case studies that illustrate innovation in psychotherapy based on accepted practice described in the literature. One such innovation involves facial mirror therapy for a traumatically brain-injured motor vehicle accident survivor with left-sided facial pain and immobility. Conclusions are offered about when in psychotherapy innovations can take place.

In the following case studies, I illustrate the difficulties therapists face in applying science to practice. The cases speak to the question to what degree therapeutic innovation should be built on and go beyond the scientific literature. Recent criticisms of psychotherapeutic practice in professional and public sources (Baker, McFall, & Shoham, 2009; Begley, 2009; Mischel, 2009) make this issue timely.

Gerald Young, PhD

Mirror Therapy for Patients in Pain and Depression

Mirror therapy for crushed leg pain

Mirror therapy has been used for cases of phantom limb pain (Chan, Charrow, Magee, Howard, Pasquina, Heilman, & Tsao, 2007; Ramachandran, & Altschuler, 2009). For example, an oblong mirror is positioned beside the intact leg so that the amputee sees together side by side the good leg and a virtual leg via the mirrored image. The legs are viewed in a normal position, for example, extended on the bed. Then, the patient is asked to move the good leg, and witnesses it and the parallel virtual leg move in synchrony. The patient perceives the movements coming from an intact leg, even if virtual. I had applied this technique to one of my patients in the following way.

My patient had a crushed left leg from a motor vehicle accident that he wants to get amputated (he is wheelchair bound), so that he can regain mobility through prosthetics. The doctors are denying his request. In addition, they indicated to him he is a poor candidate because of his chronic pain and narcotic medication dependence, which will lead to post-amputation phantom limb pain.

In order to help him with his pain, I showed him how mirror therapy works and suggested a regimen of doing this 5 times per week, 15 minutes each time. He practiced with an 18 × 34 in. mirror placed on the ground on the 18-inch side, next to his right leg, as he sat, and in his first experience of moving the left leg and seeing the right one move normally in the mirror, he found it "amazing" and felt "instant happiness." I also recommended that he initiate cycling movements lying down, with the good leg, and visualize the same with the injured one.

I explained to him Melzack's neuromatrix model of pain (Young & Chapman, 2007), and how these techniques might help alter the mental map of his pain areas. Because of the emotional component affiliated with pain, I explained that trying to smile or be positive during these exercises might help, because the matrix includes together physical sensations and psychological components. The variations that I introduced to standard mirror therapy for amputees with this patient are consistent with the literature.

Mirror therapy for intractable depression

For my next patient, I further modified the techniques described. In this case, my patient had been intractably depressed, and was complaining how recent gains have been quickly lost, despite things evolving well recently in her life. She was a workers compensation case, who had experienced major traumatic incidents following a series of subway incidents, where she works in maintenance (she witnessed jump suicides, community violence, etc.). She has been given several commendations for her helpful efforts, but the stress had overwhelmed her in the last one, and was diagnosed her with PTSD (it was rendered more complex by history of childhood abuse, partner abuse, etc.).

For her, (a) I set up one 18 × 24 in. mirror next to my computer, turned on the webcam, and induced in her smiles and a laugh. The camera was set up directly in front of her face, but she looked at the reflection in the mirror (the computer was turned to 90° to her left, and the mirror was placed on the right side at 45° or so, to permit this). Then, we replayed the tape, and she looked at it not on the screen but as a reflection in the mirror. She smiled and laughed once more. (b) In addition, she took her photo on her cell phone as she smiled, and pulled out her make-up mirror. I asked her to hold out the mirror directly in front of her and to hold the cell phone to the side at an angle so that she could see her smiling picture in the mirror. Once more, the technique was greeted enthusiastically.

I explained to her what I had done with the pain patient prior to her visit, and also explained how emotions are not only organized by way of messages from the brain to the face but also from the face to the brain. We all can smile when we really do not feel like it, and having a positive attitude, even if forced, can help.

In this case study, I could not find a reference to mirror therapy of the type used for amputees applied to purely emotional issues. Therefore, the practice was tied less directly to the scientific literature, and constituted more of an innovation.

Facial mirror therapy

For the third case, my patient had been in a catastrophic motor vehicle accident, and sustained severe brain damage, a facial smash, and multiple other injuries, including blindness

in one eye and deafness in one ear. His mother stayed with him day and night for years, working tirelessly with him, and he had made remarkable progress, confounding the specialists. In the most recent session, he focused on his pain complaints emanating from the areas in his face on the left side, where there were screws and bolts under the skin, and from his legs, with the right leg being worse. I positioned the mirror next to his left leg as he sat in his chair, and in moving his right leg he perceived the left one as healthier and moving with only a bit of pain. He was asked to use a similar mirror at home following the typical regimen.

As for the facial pain, I positioned two 18 × 24 in. mirrors without frames together on the desk, long side down, about 10° apart in the front and touching at the back end. This is wide enough to put in the opening one's face. I had him look into the opening, and see the kaleidoscope of faces that it made, which acted to create a positive mood in him. Then, he was asked to position his face at the midline on the edge of the left mirror. This resulted in a facial image in the double mirror of a face image consisting of his two right sides, in a chimeric facial figure. He thought this interesting, and practiced moving his face, smiling, etc., thereby perceiving not only the right side but also the left side of his face as moving and not in pain, in contrast to its actual state. This had the added benefit of addressing the immobility in the left half of his face due to the strokes that took place after the accident. In the present case, the corporal maps of the face that might be altered to some extent through the exercises recommended would be addressing both its pain and immobility components. As far as I know, this is the first time that mirror therapy has been used to treat facial immobility due to a stroke.

Conclusions

The innovations in psychotherapy that I have implemented present conundrums about using innovative therapy, procedures, or techniques. (a) First, the three patients described had been taught basic cognitive and behavioural strategies, and had found them helpful to some extent, depending on the day. All three needed extensive psycho-pharmacotherapy, as well. At one point in time, a team of professionals had treated each of the patients. Moreover, in my therapeutic approach, aside from the standard cognitive behavioural approach, I use narrative, systems, interpersonal, and other standard therapies, in a mix that fits the individual needs of my patients (referred to, partly, as an approach that is eclectic and that respects patient values).

Nevertheless, despite my standard training and conservative approach to practice, in session I innovated with them to varying degrees. Would a conservative approach to therapy consider that I innovated within the bounds of scientific knowledge or, rather, that I applied untested ideas to my patients before even consulting with colleagues or much of the literature to determine their possible efficacy and whether there was potential for harm? To what extent was my innovative therapeutic approach more reflective of art rather than science? (b) Furthermore, assuming that it is more scientific than art, to what extent should I have standardized it to the point that I took a preceding baseline measure (e.g., for the depressed patient, on a depression screening measure) and followed the patient course by gathering empirical data? Should innovation in psychotherapy sessions be undertaken only if there is sufficient careful data gathering, in order to protect the therapist and to protect the patient, as well as validating the technique for further use? Should innovations created in therapy be used after the first time only when its implementation has been followed for months to determine its efficacy?

Clearly, my perspective on these issues is that my therapeutic approach had been purely scientific, and not even art, consistent with the arguments raised in the paper, in that they were scientifically informed. Moreover, generally, innovation in therapeutic practice should not be constrained by fears of making errors, as long as the innovations flow from standard therapeutic approaches and reflect the scientific literature. Psychological therapy is not only the meeting ground of therapist and patient but also the meeting ground of existing practices that are scientifically informed and innovations based on them.

The validity of these statements depends on the quality and rigor in education and training of practitioners, and the degree to which they adhere to that education and training and ongoing developments in their areas of practice. There is room for innovation in psychotherapy, but it needs to be based on valid theories and techniques or procedures supported in the literature. The profession should continue to investigate the scientific basis of its practice and should prepare guidelines with respect to some of the issues raised. For example, they should illustrate how psychotherapy could proceed in terms of standard approaches, how alterations in them can be individually tailored, for example, in terms of patient values and their individual differences, yet still lie in scientifically informed practice, and how innovations in psychotherapy should stem from the scientific literature.

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Recent and New Books from Division 56 Members

Banyard, V., Edwards, V., & Kendall-Tackett, K.A. (2009). (Eds.). *Trauma and physical health: Understanding the effects of extreme stress and psychological harm*. London: Routledge.

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Drewes, A. A. (2009). (Ed.). *Blending play therapy with cognitive behavioral therapy: Evidence-based and other effective treatments and techniques*. New York: Wiley & Sons.

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Everson, R. B., & Figley, C. R. (2009). *Families under fire: A handbook for systemic therapy with military families*. New York: Routledge Psychosocial Stress Book Series.

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Greenwald, R. (2009). *Treating problem behaviors: A trauma-informed approach*. New York: Routledge.

James, R. K. (2011). *Crisis intervention strategies* (7th ed.). Belmont, CA: Brooks Cole/Centgage.

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Division 56 Needs Your Support

Are you looking for a good ***end-of-year tax deduction? Write a check to Division 56***, which is a not-for-profit organization.

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Have ideas about how to raise money for the Division? Get in touch with any of our elected officers to share your ideas.

The future of our Division depends on our dedicated Members.

Tips on Grant Writing: Perspectives from Early and Senior Career Psychologists

Judith Andersen, PhD

Included in the mission of Division 56 is the advancement of an interdisciplinary discourse and understanding of the effects of trauma across the life span. Grant writing seems to be an ever-increasing priority for research and career development in this area. If you are not already a seasoned grant writer, the process may seem overwhelming or even insurmountable. The purpose of this article is to share ideas, advice, and resource recommendations for individuals new to the process of grant writing. Below I share my experience attaining research funding during my years as a graduate student and now post-doctoral associate. In addition, in order to gather advice on grant writing and funding success from a well-seasoned expert, I interviewed Roxane Cohen Silver, PhD, a Division 56 member. Dr. Silver is a Professor in the Department of Psychology and Social Behavior and the Department of Medicine at the University of California, Irvine. An international expert in the field of stress and coping, Dr. Silver is a Fellow of both the American Psychological Association and the Association for Psychological Science.

Judith Andersen, PhD

Dr. Silver investigates the psychological, physical, and social impact of traumatic life experiences, including personal losses as well as larger collective events such as natural disasters, terrorist attacks, and other community traumas. Below I offer Dr. Silver's recommendations based our conversation, as well as discuss my own experiences in the grant writing process.

Roxane Cohen Silver, PhD

For all but 5 years of her career, Dr. Silver, a tenured professor at the University of California, Irvine, has secured extramural funding. From graduate school through present day, Dr. Silver has successfully attained six grants from the National Science Foundation (NSF) as well as funding from the National Institute of Mental Health (NIMH) and private foundations. She notes that the benefits of grant writing are numerous. Nonetheless, obtaining the funding is an overarching goal, Dr. Silver points out that even the process of writing and applying for grants is very valuable to your career. For instance, writing a proposal requires that you outline your theoretical perspective and unique hypotheses in a brief and coherent format. Learning to present your research in a very short (often a 1–5 page) proposal, while highlighting the importance of the work, sharpen's one's writing skills, which is an asset for success in obtaining peer reviewed publications. In addition, you typically get feedback from the granting agency on both your theoretical perspective and the manner in which you proposed to test it. Once leaving graduate school, detailed feedback on your ideas can be hard to come by. Successful grant getting is a combination of targeted application, multiple revisions, and often, collaborative relationships. Submitting the 'right grant at the right time' exponentially enhances your chance of success. A well-rounded team of researchers may be just the thing you need in order to get the right topic at the right time.

While the probability of attaining funding from any one agency is moderate at best, appealing to a wide audience of agencies greatly enhances your chance of success. Dr. Silver advises that the best way to do this is to keep the focus of your work on a theoretical perspective and not a particular population. For example, Dr. Silver's work focuses on various aspects of the relationship between stress and coping, such as factors that facilitate or hinder coping, and how individuals within a family respond to a trauma. She does not focus on a particular population (i.e., cancer patients or battered women). In order to understand the dynamic of coping in a dyad following traumatic exposure, she examined parent-child coping in community population exposed to school shootings. By taking a theory-driven approach, she was able to attain funding from NSF, an agency that is most interested in funding proposals that focus on theory testing and less on application. By maintaining a theory focus, agencies can see that you are developing a systematic research program from which you can test theoretical principles, describe phenomena, and discover mechanisms of significance between your predictor and outcome variables. It is the general principles and mechanisms that can be extrapolated to a wider population, rather than smaller samples of individuals.

While there are no universal "buzzwords" or grant language, funding agencies often differ in focus. Dr. Silver recommends thoroughly reviewing the agency's mission and priorities, available on most agencies' websites, before applying. Utilize the language of the agency when writing your proposal. Private organizations may focus on applied science, dissemination, and social policy, whereas the National Institute on Drug Abuse (NIDA) is most concerned with outcomes associated with drug and alcohol abuse. NIMH is most concerned with psychopathology and mental health issues rather than physical health outcome variables. It is important to understand if the agency to which you are applying most often funds projects focused on outcome or predictor variables, theory testing, or application. You may want to avoid terminology that limits your appeal to a wide audience, such as specific psychological conditions (e.g., PTSD). Rather, it's best to focus on the effects of trauma exposure in general or the factors associated with trauma exposure and suicide, within which an examination of disorder specific variables may be examined. By incorporating the

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Tips on Grant Writing

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examination of alcohol or drug use into your studies, you may also consider applying to NIDA or the National Institute on Alcohol Abuse and Alcoholism (NIAAA), even if your research is not focused on substance use. Other funding opportunities that are often overlooked by psychologists are National Institute of Nursing Research (NINR, part of NIH), the Department of Defense (DOD), and the Department of Veteran's Affairs (VA). You are not required to be a nurse or obtain medical training in order to apply for nursing research funds. The DOD and VA *do* fund projects that are not military specific and are another avenue for investigation; topics of interest include family dynamics following trauma or health related studies such as smoking cessation or research regarding obesity. Early career research and career development grants are also excellent options for early career psychologists. The NIH offers K-award training grants that aid individuals transferring from post-doctoral to assistant professor status. In addition, NIH issues R21 grants that have a focus on utilizing innovative methodology to test theory-based proposals. These brief 2-year grants are a great way for early career psychologists to lay a solid foundation for a unique program of research.

In my own experience as a graduate student and post-doctoral associate, I have attained research funding for 5 of the 7 years of my career. A strategy that I found to be successful has been to start small. Starting small made the process less overwhelming, and did not take the focus away from other training priorities, such as course work and publishing. I have successfully obtained 5 grants for pilot work and career development that ranged from $1,200 to $12,000, and one for the use of research equipment. Early in graduate school, my advisor, who was notified of the opportunity via an email on a listserv, tipped me off to the first opportunity for funding. Funded by the National Institute of Aging, the Center for Population Economics was requesting sub-grant proposals

Source	Website
Professional Organizations	
International Society of Traumatic Stress Studies Student Grant	http://www.istss.org/Content/NavigationMenu/Students/StudentArea/StudentResearchGrantApplication_1.pdf
Association of Psychological Science Student Grant	http://www.psychologicalscience.org/apssc/awards/
American Psychological Association	http://www.apa.org/science/about/psa/2010/03/funding.aspx http://www.apa.org/about/awards/index.aspx
APA Division Funding	**Below are just some of the APA divisions that offer student or career funding. Many divisions offer funding and a comprehensive list can be found at apa.org**
Division 38 Health Psychology Student Grants	http://www.health-psych.org/StudentsAwards.cfm
Division 44 Lesbian, Gay, Bisexual, and Transgender	http://www.apadivision44.org/honors/
Division 45 Study of Ethnic Minority Issues Student Awards and Fellowships	http://www.apa.org/divisions/div45/students.htm#funding
Institutional Funding	**Check your specific university or organization website**
NIH issues Exploratory/Developmental Grant (R21)	http://grants.nih.gov/grants/oer.htm
NSF includes helpful writing guide to aid in proposal preparation for NSF's early response RAPID (rapid response research grant). RAPID grants fund early response research.	http://www.nsf.gov/funding/
National Institute of Nursing Research	http://www.ninr.nih.gov/
Private Organizations	
John D. and Catherine T. MacArthur Foundation	http://www.macfound.org/site/c.lkLXJ8MQKrH/b.3599935/k.1648/John_D__Catherine_T_MacArthur_Foundation.htm
Ford Foundation	http://www.fordfound.org/grants
Psychology Beyond BordersMission Awards	http://psychologybeyondborders.com/MissionAwards.aspx
Websites	**Resources that help you decide if you should apply for funding, and the process of doing so**
Federal Grants	http://www.federalgrants.com = excellent information for writing grants and tips on preparedness and "fast grant search" is a good addition to the mix
Grants.gov	http://www.grants.gov/
Automatic Grant Alerts	**Websites at which you can sign up for automatic alerts on relevant grant topics to be sent to you.**
http://www.scangrants.com	http://fundingopps.cos.com/ http://www.scangrants.com http://www.apa.org/about/awards/ http://www.psychfoundation.org/GrantAndAwards.aspx

for the examination of existing historical data on soldiers with lifespan health records. As this organization was comprised of economists and historians, my approach to examining the effects of trauma exposure on life-span health and mortality was unique. This grant led to subsequent funding from the same source. In addition to agency funding, I have received a small career development award from the Central New York Research Corporation. This organization functioned as the clearinghouse for NIH grants awarded to investigators in the Veteran's Hospital in Central New York. I inquired about opportunities for funding and successfully attained a small career development award after submitting a brief proposal. Additional funding sources to which I have applied include university-specific institutional awards. I make it a priority to check for funding opportunities often via agency websites and grant alert emails. I inquire about university-related funding and continue to build collaborative relationships with colleagues who are interested in jointly applying for grants. I also make a practice of reading successful grant applications, with specific attention to the agencies to which I am applying. Grant agencies sometimes post successful grant applications on their website. If not, grant agencies should make the names of successful grant recipients available to you. I have emailed recipients until I found someone who was willing to let me read their grant application. I have also asked my graduate school advisor and other colleagues who I know have successfully attained grants and they were willing to let me read their proposals. This practice has been helpful in learning how to write a Specific Aims section in the grant application, which is a critical but often challenging component to any proposal. Another technique I have found to be helpful is to have a non-psychologist read my specific aims; if I can communicate my research idea and the importance of the work coherently, then that person should understand what I am doing. Although a number of my grant applications have not been successful, the practice and feedback have been invaluable as I now look to applying for NIH early career awards.

Overall, grant writing is a highly recommended exercise for an early career psychologist. However, as a faculty member who has reviewed many academic job applications and served on many hiring committees, Dr. Silver stated that grants are not expected for early career candidates to be attractive to hiring committees. Attaining an early career grant is viewed as a bonus; so do not despair if you are on the job market sans grant funding. I hope this advice is helpful to you as you begin the process of applying for research grants. On the previous page (p. 24), you will find some resources that might be of help in your search for appropriate grant agencies. There are websites that offer the option of e-mailing you new grant opportunities automatically, which you may also find helpful.

Judith Andersen received her doctorate in Psychology and Social Behavior from the University of California, Irvine and is currently a Post-Doctoral Associate at Cornell University. Her research examines the biological and psychological mechanisms by which the experience of extreme stress influences physical health across the life span. She was funded to conduct an archival analysis of military and medical records to examine the effects of war experience on the physical and mental health of Civil War veterans and current analysis of veterans of the Iraq/Afghanistan War. In addition to longitudinal data analysis on population samples of adults exposed to the terrorist attacks of September 11th, 2001, she has conducted experimental laboratory research on the biological mechanisms of stress in samples of women of childbearing age. She has published this work in journals such as the Archives of General Psychiatry, Health Psychology *and abstracted in* Science.

Division 56 Hospitality Suite

Division 56—Trauma Psychology Hospitality Suite at APA to be located in the San Diego Marriott Hotel & Marina.

Attention ECPS Who Are Attending APA

Early Career Psychologists who will be attending APA this August: Please contact Lisa Cromer if you are interested in participating in ECP activities at APA. In particular, we are arranging mentorship meetings, so if you would like to sit in on individual meetings or small group discussions, or if you want to learn more about what we are planning, contact Lisa at lisa-cromer@utulsa.edu or 918-631-2267.

ECPs Research Networking

The Research Networking Subcommittee is piloting a Google/wiki site as a directory of ECPs who are looking to network and collaborate with other ECPs. This is a great way of finding colleagues with similar interests and compatible resources. To learn more, please contact Molly Fechter-Leggett at drfechterleggett@gmail.com.

Student Spotlight

Tara Samples
Student Publication Subcommittee Co-Chair

Student members of Division 56 are making important contributions to trauma psychology. In acknowledgement of the contributions of students, the Student Affairs Committee is pleased to share with you the contributions of one remarkable student member, Lindsey Zimmerman. In this issue, Tara Samples, Student Publication Subcommittee Co-Chair, chose to spotlight her colleague, Lindsey, because they share a commitment to community advocacy in clinical psychology as well as a commitment to promote culturally informed trauma intervention and research. Lindsey provides an outstanding example of scholarship, community advocacy, and clinical skill. We are honored to introduce Lindsey Zimmerman to the trauma psychology community.

Tara Samples

Lindsey Zimmerman is a rising force in the field of trauma psychology. She is a doctoral candidate in the dual clinical and community programs at Georgia State University (GSU) and the most recent recipient of GSU's Doctoral Fellowship in Trauma Intervention for her commitment to trauma prevention/intervention work in her community and internationally.

Trauma work became important to Lindsey Zimmerman early in her academic career. "As I learned about the realities of domestic violence, and the shortage of necessary community resources, I was scandalized." As an undergraduate and graduate student, Lindsey became a community advocate, a researcher, and clinician, working with individuals impacted by Hurricane Katrina, HIV/AIDS, homelessness, suicide and intimate partner violence. Lindsey found community psychology's focus on primary prevention a hopeful approach providing balance to her clinical intervention work. "From the perspective of my dual training, trauma prevention and intervention are best conceptualized from a combination of both clinical and community psychology. Diagnosis with post-traumatic stress disorder requires an event in the individual's environment, which suggests that it is possible to prevent those contextual triggers. But, because traumatic events do occur, empirical research to identify the most effective clinical interventions remains essential." Throughout her academic training she has maintained a dual focus in both prevention and intervention. "Trauma work is important—I want to intervene with individuals who have experienced traumatic events, but I also think it's important to work beyond individual-level risk-reduction and work to empower communities to prevent violence."

Lindsey's dedication to intervention and prevention efforts is demonstrated through her involvement in a number of trauma-focused projects. Lindsey is both a clinician and a researcher at Atlanta's Grady Memorial Hospital. She works with the Grady Nia Project under the supervision of Dr. Nadine Kaslow and provides early intervention in Grady's Level One Trauma Emergency Department (ED) supervised by Dr. Barbara Rothbuam, both of Emory University School of Medicine. The Grady Nia Project is an evidence-based and culturally informed prevention/intervention program for African American women survivors of interpersonal violence and suicide. The ED project is an early intervention randomized clinical trial seeking to assess whether prolonged exposure sessions immediately after a traumatic event can prevent the onset of PTSD.

Lindsey Zimmerman

Through Atlanta's Caminar Latino, Lindsey is a group and family therapist with Latino children impacted by domestic violence. Lindsey is also a research assistant on the CDC and NIH-funded Violence Against Women Prevention team at Georgia State University, under the direction of Sarah Cook, PhD.

Lindsey's interests in trauma intervention and prevention extend to her dissertation project, which is focused on the development and implementation of a culturally competent, trauma-informed, family-based intervention to prevent HIV among youth in South Africa. Led by co-principal investigators Lisa Armistead, PhD, and Sarah Cook, PhD, of GSU, and Donald Skinner, PhD, of Stellenbosch University (South Africa), the project is investigating the most effective ways to implement evidence-based interventions developed in the U.S. and adapt them to other cultures and contexts.

Lindsey believes that the future of trauma psychology lies in continuing to bring together research on cultural competence with evidence-based intervention so that the two fields of psychology become increasingly aligned. When asked about her career goals Lindsey stated "I'd like to remain in an academic or hospital environment and pursue an intervention research program that includes both primary prevention and effective empirically-supported treatments." Lindsey Zimmerman, scientist, practitioner and advocate is a student psychologist shaping the face of tomorrow.

We want to hear about the work and contributions of student members. If you or a student you know is interested in being featured in our Student Spotlight, please e-mail the co-chairs of the Student Publication Subcommittee, Tara Samples (tarasamples@yahoo.com) and Nathan Moon (nathan.moon@pepperdine.edu). We hope to feature a student member of Division 56 in every spring issue of the *Trauma Psychology Newsletter*.

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and colleagues—inspire me to want to do more, and do it better, within this organization that we have brought to life.

Trauma Psychology and Health Care Reform

Being President of Division 56 offers me opportunities to do more and perhaps better for trauma survivors and the study of trauma by making our organization as robust and effective as possible. Because of our presence in the family of APA, Division 56 has been in a position to influence public policy, not the least of which is the enormous public policy that is U.S. health care reform, signed into law by Barack Obama the week before I wrote these words. Division 56's Policy Committee Chair, the gifted Diane Elmore, had a hand in creating some of the provisions of the health care bill. This means that the study and treatment of trauma, and even more importantly, the prevention of trauma, are now enshrined in the health care policy of the U.S. for what I hope will be many years to come. Some of the provisions that Diane and other members of APA's Government Relations Office staff helped to write into that law include:

- creating a comprehensive approach to preventing, detecting, treating, understanding, intervening in, and, where appropriate, aiding in the prosecution of elder abuse, neglect, and exploitation
- prohibiting insurers from establishing rules for eligibility based on pre-existing conditions (including conditions resulting from acts of domestic violence)
- promoting interprofessional health care that incorporates the integration of physical and mental health care and provides training in the care of vulnerable populations, such as victims of abuse or trauma
- supporting early childhood home visitation programs to promote reductions in child abuse, neglect, and injuries
- providing grants for training to accredited master's, doctoral, internship, and post-doctoral residency programs of psychology for the development and implementation of interdisciplinary training of psychology graduate students for providing behavioral and mental health services (with priority given to institutions in which training focuses on vulnerable groups, such as victims of abuse or trauma and of combat stress disorders).

While APA's Public Interest Directorate, under the able leadership first of Henry Tomes and now Gwendolyn Puryear Keita, has always been a home in APA for understanding issues of interpersonal violence and discrimination, the fact that Division 56 exists adds something important and invaluable to APA's ability to represent the concerns of trauma psychologists. All of this is a prelude to my invitation to you, the members of Division 56, to take part in the process of making the Division the best place it can be to nourish each of you and the work that you do.

Come to the Social Hour and Applaud

Our Awards Social Hour will be taking place on Friday, August 13th, at 8 pm, in the Manchester Room at the San Diego Marriott Hotel. There will be snacks, a cash bar, and most importantly, the announcement of this year's award winners. Please come and offer your congratulations to our distinguished colleagues! This'll also be a good chance to schmooze with all of us. Your friends and colleagues who are not yet Div. 56 members, as well as your family, are all also welcome to join us.

Come to the Business Meeting in San Diego and Be Heard!

Our Division's Business Meeting will be taking place on Saturday, August 14th, at 5 pm (right after yours truly giving a presidential address at 4 pm), in the San Diego Convention Center, Room 25C. This year our business meeting is going to be all about you. Rather than make you sit through a recitation of what we've been doing this year, we're going to publish our committee reports in the Fall newsletter, and instead devote this meeting to an interactive exchange between you and the division's leadership. Please come prepared with your answers to these questions:

- What does Division 56 need to do in the next five years to keep you as a member?
- What does Division 56 need to do in the next five years to get your friends who aren't members yet to join?
- What does Division 56 need to do to get you active in the Division?
- If you were President of Division 56, what projects would you lead us to?

We'll be creating small groups, facilitated by our leadership team, to discuss your answers and bring them together. My past-presidential project will be to take your answers and see what we can do as an organization to respond to them. It's been my experience that while few people are in a position to take on leadership roles in an organization, many have excellent ideas that rarely are heard or known. I'm committed to doing my best to make space for the voices of those of you who, for whatever reason, do not choose to be active (yet) in the Division. It's an experiment. Like the daffodil that's decided to bloom in the middle of my yard, it may continue to flower—it may not. I promise that your ideas will not fall into a hole never to be seen again. Some of you may see your suggestions in my final presidential column!

Walking our Social Justice Talk—Division 56 and the Manchester Hyatt

Finally, a word about the 2010 APA Convention. As some of you may already know, APA learned in late 2008 that the owner of one of the hotels for which it had signed a contract in 2004, the Manchester Grand Hyatt, had personally donated a quarter of a million dollars to the

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campaign for Proposition 8. Prop 8 was the 2008 California ballot initiative that stripped lesbian, gay, and bisexual Californians of the right to legally marry that had been conferred on them by the California Supreme Court only months earlier.

This ballot initiative, and the loss of the precious civil right of marriage equality, were painful to many people, not only to LGB California residents whose right to marry was taken from them. As our colleague Glenda Russell's research has shown, ballot initiatives challenging our civil rights have negative effects on the mental health of sexual minority people in general, as well as that of our heterosexual family members and allies. The Manchester Hyatt was slated to be APA's headquarters hotel at the convention, with the APA Council of Representatives' meetings scheduled there. The price for breaking the contract with the Hyatt was steep—and APA was in the middle of a financial crisis, due to the collapse of the U.S. economy in late 2008, which led to the layoff of 32 staff members in summer 2009.

Division 56 joined with a number of other groups within the association calling on APA to respond to Mr. Manchester's actions, which were in direct opposition to APA's policies about marriage equality and its values about non-discrimination. While not everything that Division 56 and our allies asked for is going to happen, I'm pleased to let our members know that APA's Council of Representatives voted overwhelmingly in February to move its meeting out of the Manchester Hyatt. It will cost APA some money, and that cost was considered well worth it for APA to walk its talk. Division 56 will have none of its programming in the Hyatt. We will be in the Convention Center and in the Marriott. Under the leadership of APA's current president Carol Goodheart, APA will be offering programming on topics related to marriage equality as a means of raising consciousness further about this topic.

Our Executive Committee worked together to write our letter to APA, which we shared with you on the Division's member listserv. We are proud to have walked our talk about social justice, and to have educated APA's leadership about how social injustice is traumagenic. While I know that not all members of Division 56 share my perspective on the matter of marriage equality, I hope that many of you will see the value of each of us taking action. Trauma psychologists do not live, practice, research, teach or create policy in ivory towers or at a distance from painful realities. We occupy the often invisible world of the frightening, unpredictable, and disempowering things that occur in human lives. For me, action in the face of injustice, and doing what I can to prevent human suffering, is inextricably woven into the fabric of my identity as a trauma psychologist.

I'm looking forward to seeing many of you in San Diego. Please say hello—come to the business meeting, to our social hour. Come hang out in our hospitality suite, and take the opportunity to spend time with the students and early career psychologists who will be staffing it. Come to our programs (and imagine yourself on the program in Washington DC in 2011). Consider saying yes when you're asked to serve on a committee or task force. Take action, because our work brings life back to the numb, cold places of the human spirit that have been visited by trauma.

Early Career Psychologists/Membership Discount!

If you are an early career psychologist (ECP) and wish to join or renew your Division 56 membership, you will receive a $10 discount! According to APA, you are an ECP if you have received your doctoral degree within the past 7 years. If you are an ECP, and wish to take advantage of the discount, note on your application form that you are an ECP when you include your payment of $35. This includes the division journal and full membership benefits. Questions can be directed to Lisa Cromer, ECP committee chair, at lisa-cromer@utulsa.edu.

We're interested in our Members…

Kathy Kendall-Tackett

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

Special Interest Group Meeting in San Diego

Stacey Seibel, PhD

There will be a meeting in the Division 56 hospitality suite for the Special Interest Groups (SIGs) at the annual APA convention in San Diego. Please join us to learn more about the SIGs, how you can become actively involved, and to discuss ways to enhance the benefits of the current SIGs. This meeting is intended for interested members and current SIG members. Details TBA on the website (www.apatraumadivision.org) once the suite program is finalized.

Disaster Relief and Response

Division 56 Members with interest in providing mental health services after natural disaster trauma might consider joining the Disaster Relief and Response Special Interest Group of Division 56. This SIG provides a forum for discussions on best practice and dissemination of research in the area of post natural disaster trauma.

If interested, please contact the SIG chair, Angeleque Akin-Little, at drsakinlittle@netzero.net.

The Division of Trauma Psychology-Your Home in APA

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.

Why join Division 56?

If you do research on any aspect of traumatic stress, join to further develop the growth of the scientific basis of the field and to meet other professionals working in trauma psychology.

If you work with survivors of trauma, join to become part of the conversation about treatment and research on intervention, and to meet other professionals working in trauma psychology.

If you teach a course on trauma, join to meet colleagues and develop and learn the cutting-edge research and literature for your classes.

If you work on trauma related public policy, join to make sure the expertise of trauma experts is brought to bear on the tough issues APA takes on.

Member Benefits

- Members keep up-to-date on the latest developments in trauma psychology.
- E-newsletters with timely information on traumatic stress are delivered directly to your in-box
- 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.
- Our journal, Trauma Psychology: Theory, Research, Practice, Policy at the member rate of 20.00 per year. You do not need to separately subcribe 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 journals in the field of trauma. To receive these discounts, contact Haworth directly at 1-800-429-6784 (607-722-5857 outside US/Canada) or order on-line and provide the code # TPD20.

Membership Categories

Membership in Division 56 is open to individuals who are not members of APA, in the Professional Affiliate Category. Current students who are APAGS members receive their first year of membership for free, with the option to pay 20.00 to receive the division's journal. Non-APAGS students, and continuing student members, pay a low 10.00 fee, with the option to receive the journal for 20.00. Early career psychologists (ECP) within seven years of receiving their doctorate are eligible for a special rate of 35.00, which includes the journal. APA Associates, Members, and Fellows dues are 45.00, which includes the division journal.

Join Division 56 Now!

Membership Category	Rate	Journal
☐ APA Associate, Member or Fellow	45.00	included
☐ Professional Affiliate	45.00	included
☐ Early Career Psychologist	35.00	included
☐ First year APAGS	Free	20.00
☐ Student	10.00	20.00

Total: _____

Name

Address

APA Member Number

Phone and email

Method of Payment

- ☐ Check payable to Division 56
- ☐ Visa
- ☐ MasterCard
- ☐ American Express

Credit Card # Exp. date

Signature

Send your completed application to
APA Division Services
750 First Street NE
Washington DC 20002-4242

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www.apatraumadivision.org/join.php

DIVISION 56 TRAUMA PSYCHOLOGY AMERICAN PSYCHOLOGICAL ASSOCIATION

Is your professional liability protection as good as you think?

Does your policy have these coverage features?

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Protection for investigations of violations of the HIPAA Privacy Rule	❑	❑
Protection for Medicare or Medicaid payment investigations	❑	❑
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Increased reimbursement limits for *"Loss of Earnings"* and *"Premises Medical Payments"*	❑	❑

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