



DIVISION 56

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

NEWSLETTER

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Presidential Voice

Remembrance & Re-building:
Lessons of Trauma from 9/11

Christine A. Courtois, PhD, APBB

This is my final column as President of Division 56. I have been honored to serve in this capacity this year and wish to thank leaders and members of the Division for their enthusiasm and support. Also, I'd like to mention that our membership campaign is on a roll and we are adding members monthly. **Please remember to tell friends and colleagues about Division 56 and all of its benefits, especially our impressive Journal and Newsletter, in addition to involvement with a wonderful group of professionals.** We continue to build our influence within and outside of APA with the size of our division, our breadth of topic areas included, and the diversity of our membership and interests.

Let me begin this column by reporting on news of the division and division activities at the recent APA conference, a busy one for all. Our programming, under the direction of Program Co-Chairs **Kate**

Richmond and **Sylvia Marotta** was very well-received and covered a number of significant new areas of interest in the trauma field. Thanks to both of these outstanding organizers! Please take a look at the Division website for recordings of many of these sessions, including outstanding plenaries by **Sandra Bloom, MD, Laurie Pearlman, Patricia Crittenden, PhD, the 9/11 panel** (more on this on pages 22-23), and my presidential address. At our awards ceremony and social, we honored the following individuals:



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Outstanding Contributions to
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Jennifer J. Freyd, PhD,
Outstanding Contributions to the
Science of Trauma Psychology

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Trauma, Death, & Resurrection: A Conversation Between Robert D. Stolorow and Sergei Roganov

Editor's note: This conversation is quite thought-provoking, and some readers may find it controversial. Letters to the Editor are welcome and should address issues and matters of fact. Attacks against persons are not acceptable. Limit 200 words. Send to: info@ruthblizard.com.

Robert D. Stolorow (RDS): You were kind enough to contact me after reading my article, "The Meaning and the Rhetoric of Evil" in the *Russian Journal* (English *HuffPost* version: http://www.huffingtonpost.com/robert-d-stolorow/the-meaning-and-the-rheto_b_884927.html), in which an article of yours was also published. Drawing on ideas first elaborated in my book, *Trauma and Human Existence* (Routledge, 2007), I claimed that the essence of emotional trauma, individual or collective, lies in the shattering of what I called the "absolutisms of everyday life," the system of illusory beliefs that allow us to function in the world, experienced as stable, predictable, and safe. Such shattering is a massive loss of innocence exposing the inescapable contingency of existence on a universe that is chaotic and unpredictable and in which no safety or continuity of being can be assured. Emotional trauma brings us face to face with our existential vulnerability and with death and loss as possibilities that define our existence and that loom as constant threats.

You have written about collapse, irreversible trauma, and social death. Do you see a connection between your ideas about these phenomena and my conception of a traumatic shattering of an emotional world?

Sergei Roganov (SR): Certainly, I do see a deep connection between my concepts of death and mortal being and your interpretation of trauma. Collapse of the USSR was a self-inflicted Holocaust, which absolutely destroyed "absolutisms of everyday life". I claim that "collapse" of the state/superpower means annihilation – *irreversible* loss of "absolutisms". But irreversible annihilation means one thing – death. Until now one could use "death" only as metaphor or symbol, because it has been thought that only a biological organism may die, not history, societies – the world of psyche and consciousness. But now, modern biotechnologies, aging studies, and bioethics establish an absolutely new image of human death and human mortality. It is the loss of consciousness/psyche that now becomes the main criterion of death. Societal "collapse" means not only collapse of social and governmental institutions but of mind itself – of the ability to think, feel, or function. Such inabilities are the main characteristics of the "death of consciousness" criterion! That is why my essay, "USSR's collapse through the eyes of Trisha Marshall [a brain-dead pregnant woman whose life was maintained by artificial

methods until her child was born]" (*Russian Journal*, 2011, <http://www.russ.ru/pole/Kollaps-SSSR-i-Trisha-Marshall>), provides readers with an interdisciplinary approach, combining traditional collapse studies with American bioethics metaphors.

In line with this modern meaning of death, do you think your idea of "ideological resurrection" now gets a deeper meaning?

RDS: I very much like your idea of irreversible trauma being a form of death. Your idea brings to mind Heidegger's crucial distinction in *Being and Time* between death as an event, which he calls "demise," and death as an existential structure – a possibility that determines how we understand ourselves in our futurity and our finitude. When we own up to death as a constitutive possibility that defines our temporal existence, Heidegger claims, we experience existential anxiety – the significance of our everyday world collapses and we feel homeless. I have contended that these two features – collapse of significance and homelessness – are central to the experience of trauma, individual or collective. When a nation or society collapses, as happened with the USSR, a world of human significance and sense-making collapses along with it. For Heidegger, such world-collapse is existential death. You, Heidegger, and I are in harmony here.

Now I will add something controversial, with which you might agree. It is my contention that all trauma, in its essence, is irreversible. Innocence lost can never be regained. In my new book, *World, Affectivity, Trauma* (Routledge, 2011), I claimed that "trauma recovery" is an oxymoron – human finitude with its traumatizing impact is not an illness from which one can recover. "Recovery" is a misnomer for the constitution of an expanded emotional world that coexists alongside the absence of the one that has been shattered by trauma. The expanded world and the absent shattered world may be more or less integrated or dissociated, depending on the degree to which the unbearable emotional pain evoked by the traumatic shattering has become integrated or remains dissociated defensively, which depends in turn on the extent to which such pain found a context of human understanding in which it could be held.

When their worlds have collapsed, especially when there is no "relational home" for their emotional pain, traumatized people often try to restore the lost illusions shattered by trauma through some form of what I have called "resurrective ideology." This brings me to your question, because if the traumatic collapse of a world is irreversible, a form of existential death, then attempts to resurrect it can only be illusory, as was illustrated dramatically in post-9/11 America.

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Stolorow and Roganov Conversation...

continued from p. 3

The terrorist attack of 9/11 was a devastating collective trauma that inflicted a rip in the fabric of the American psyche. In horrifyingly demonstrating that even America can be assaulted on its native soil, the attack of 9/11 shattered Americans' collective illusions of safety, inviolability, and grandiose invincibility – illusions that had long been mainstays of the American historical identity. In the wake of such shattering, Americans became much more susceptible to resurrective ideologies that promised to restore the grandiose illusions that have been lost.

Following 9/11, the Bush administration declared war on global terrorism and drew America into a grandiose, holy crusade that enabled Americans to feel delivered from trauma, chosen by God to rid the world of evil and to bring their way of life (= goodness) to every people on earth. Through such resurrective ideology and its rhetoric of evil, Americans could evade the excruciating existential vulnerability that had been exposed by the attack and once again feel great, powerful, and godlike.

Tragically, every effort to actualize such ideological illusions inflicts collective trauma on those who are attacked, and they respond with an intensification of *their* resurrective ideologies. It is this dialectic of traumatic collapse and ideological resurrection that fuels the lamentable, endlessly recurring cycle of atrocity and counter-atrocity that has been so characteristic of human history.

Did you witness similar instances of a rise of resurrective ideology following the collapse of the USSR?

SR: First, I'd like to return to your important idea concerning American resurrective ideology: "feel great, powerful, and godlike". "Godlike" – a key image! Let me remind you of Dostoevsky's hero/oxymoron Kirillov – the "man-god," of Nietzsche's "overman," and of Nicolay Bukharin's slogan, "Communism is a collective man-god!" "Godlike" is a crucial theme for understanding symbolic resurrection's pervasiveness in superstates. Several years ago I wrote an article, "Two Worlds – One System" (*Nezavisimaya Gazeta*, http://www.ng.ru/politics/2002-04-08/2_system.html), in which I compared the USSR and USA. My first trip to the USA was like returning to the USSR of the 60s. It is their godlike ideology that unites the two seemingly opposite cultures and political systems.

As to your "resurrective ideology," all of Russia's relations to its closest neighbors manifest such ideology. Moreover, any political programs, national

projects, or international relations of Russia are based on "resurrective ideology". This applies to opposition, ruling party, and elites. First and foremost, our prime minister, Vladimir Putin, is an apostle of resurrection. If you read attentively the texts of his speeches and notes, you'll find profound Soviet rhetoric there – for him the fall of the USSR was the worst catastrophe. But neither Putin nor Russian elites and society are able to declare or realize a "holy crusade." That is the core problem – the reality of our society's collective trauma/death after USSR's collapse. The same is true for any post-Soviet

states – there is a crucial inability to realize any new steps together and gain fruitful results. Instead we have "godlike" power attributed to one person.

Certainly, it is absolutely impossible to restore/resurrect the former USSR, and, for post-Soviet generations, that impossibility is a profound existential death, a collapse of their everyday world. Look attentively at the current status of the former socialist world and you'll find many manifestations of resurrective right-wing rhetoric and pro-fascist politics and public persons – in Hungary, Bulgaria,

Poland, and so on. But that does not mean any real possibility for establishing totalitarian fascist or communist institutions. Societies are not able to communicate and collaborate; and signs of totalitarian rhetoric mean only one thing: paradoxical resurrective ideology that, truly speaking, is not "ideology" at all. Dead societies display a symbolic modern *Danse Macabre* and nothing more (see review of my article, "Putin's System Represents the Triumph of the 1970s Generation": http://georgiandaily.com/index.php?option=com_content&task=view&id=15734&Itemid=134). Putin and his close circle in reality have established a "mortal God," a Leviathan "to secure the State monopoly of power, with top priority in time and resources" (Daniel Thürer, "The Failed State and International Law," *International Review of the Red Cross*, No. 836).

So, the logic of post-collapse trauma understanding is constituted by:

- 1) collective "man-god",
- 2) death of God/USSR,
- 3) "mortal God" (Leviathan), and
- 4) ideological resurrection.

The irreversibility of trauma/death sets a very narrow way not only for inhabitants of former socialist states, but for millions of migrants too. So psychotherapy for such people seems doomed to collapse; and here we may need to start rethinking our methods and ways of therapy.

"Collapse" can mean a potentially *reversible state* of society and individuals. But *irreversible trauma* after collapse means: "death of consciousness, will, psyche".



Robert Stolorow, PhD, PhD

How is it possible for experts to combine these two incompatible visions of reality for rebuilding states and social institutions? You wrote, “trauma recovery’ is an oxymoron,” and here I absolutely agree with you. BUT, what can we propose to those who suffer? People want real assistance. What would you advise?

RDS: Over the course of the twenty years that have followed the death of my former wife – a world-shattering trauma for me – I have focused my efforts on the understanding of, and the therapeutic approach to the experience of emotional trauma. From the vantage point of emotionality, trauma is an experience of unbearable emotional pain. I have claimed in my last two books on trauma that the intolerability of an emotional state cannot be explained solely, or even primarily, on the basis of the quantity or intensity of the painful feelings evoked by an injurious event. Painful emotional experiences become unendurable – i.e., traumatic – when the emotional understanding we need to help us bear such pain is profoundly absent. Psychoanalytic therapy with traumatized people begins by establishing just such a “relational home” of human understanding, within which traumatized states can evolve into painful emotional experiences that can be more fully felt, lived-in, better tolerated, brought into language and conversation, and eventually better integrated (but never reversed).

How can such therapeutic principles be extended beyond the narrow confines of the consulting room? Imagine a world in which providing deep understanding of others’ existential vulnerability and emotional pain – that is, of the potentially traumatizing emotional impact of our finiteness – has become a shared ethical principle. In such a world, human beings would be much more capable of living in their existential vulnerability, rather than having to revert to the defensive, destructive ideological evasions of it that have been so characteristic of human history. A new form of individual identity would become possible, based on owning rather than covering up our existential vulnerability. Vulnerability and pain that find a hospitable and understanding home could be seamlessly woven into the fabric of whom we experience ourselves as being. A new form of human solidarity would also become possible, rooted not in shared ideological illusion but in shared recognition of and respect for our common human limitedness. If we can help one another bear the darkness rather than evade it, perhaps one day we will be able to see the light – as



Sergei Roganov, PhD

finite human beings, finitely bonded to one another.

Do you think the wonderful conversation we are having might be a tiny step toward that goal?

SR: “A new form of individual identity” – I agree with you, and that is the main issue of my research and writings. I think, now in a world of globalization, a world in which not only states but branches of industry are collapsing, and a world of terrorism and wars of biotechnologies, we should think about a new image of man as *Homo mortalis*, who knows and understands the limits of his thoughts and actions and is aware of the finiteness of human existence.

I am very glad to talk with you and hope our conversation will continue.

Sergei Roganov, PhD - Russian writer, journalist, and author of *The Gospel from Man-God*. Posthumously. Personally. (Moscow, AST, 2005), *Almanac Homo mortalis – Mortal being* (Printing House, Ltd., 2009) – *List of 50 best non-fiction of Exlibris – NG, 2009*, and coeditor of several other books. He is an expert on modern phenomena of death, personal and historical death, death of generation; USSR’s collapse, the death of Soviet values and communism system, modern culture of historical death; and *Bioethics, the history of biological death definition, social implication of “brain death concept”, euthanasia, self-death – social context*. Author and screenwriter of the first Russian documentary TV series on *Modern Phenomena of Aging & Death in the light of biotechnological developments*. He has graduated Kiev State University and received his PhD in Social Philosophy from Moscow Institute of Philosophy in 2006. He was visiting scholar at The Hastings Centre (NY, USA) in 2005 and IZEW at the University of Tübingen in 2006.

Robert D. Stolorow, PhD, PhD is a Founding Faculty Member at the Institute of Contemporary Psychoanalysis, Los Angeles, and at the Institute for the Psychoanalytic Study of Subjectivity, New York City. He is the author of *World, Affectivity, Trauma: Heidegger and Post-Cartesian Psychoanalysis* (Routledge, 2011) and *Trauma and Human Existence: Autobiographical, Psychoanalytic, and Philosophical Reflections* (Routledge, 2007) and coauthor of eight other books. He received his PhD in Clinical Psychology from Harvard University in 1970 and his PhD in Philosophy from the University of California at Riverside in 2007. •

The Intersection of Forensic Opinion & Therapist Testimony in Custody Cases

Editor's note: This column will discuss legal issues related to Trauma Psychology. The author welcomes comments as well as questions to be addressed in future issues.

Toby Kleinman, Esq., toby@adlerkleinman.com

One of the most difficult tasks for any trial attorney during a contested child custody case is determining who should testify and in what capacity. Once it is determined that an expert opinion will be of assistance to the court, the lawyer must choose what type of expert will be most beneficial, if a forensic evaluator or a treating therapist. However, questions often arise from reluctant treating therapists when they are asked to testify. I query whether or not there should be any dilemma.

For the court, an individual can be qualified to testify and give opinion testimony as an expert so long as they have more than a lay person's knowledge of the subject matter. All psychologists presumably meet that standard and thus the question for the attorney is merely whether or not an evaluation of an individual or individuals will yield the desired information for the case before the court. If not, would it be better to have someone's therapist testify instead of, or in addition to, a forensic evaluator?

In domestic violence and child protection cases, the answer as to who testifies is a critical one and it may make the difference between a child being protected by the court or the court placing a child 'at risk' in the home of a batterer or a child abuser. Most frequently a therapist is a crucial conduit to the court understanding the totality of a victim's circumstance.

It is well known that many forensic evaluators are selected by courts to perform custody evaluations. Many of these people are not sufficiently trained in areas of trauma to be evaluating individuals who suffer from trauma and trauma related illness, such as Battered Woman's Syndrome and child abuse.

Too often courts assume that the credential of licensure or equivalent degree is sufficient to make someone an expert. Too many lawyers don't know the distinctions, so they do not properly cross examine. The courts are then left to rely upon unqualified experts. In some states you are not permitted to hire your

own expert until a court appointed person renders an opinion. The litigant's expert then has an even more difficult task.

If the 'under-qualified' forensic evaluator renders an unsupported opinion because he lacks requisite knowledge or expertise to have conducted an evaluation of a domestic violence or child abuse issue in the first place, a therapist for the battered spouse or abused child can counter this inadequacy. The therapist can create context, give documented history and also correct inaccurate interpretations. Doing so may change the perception of the court without it appearing as if there is

a war of the experts. Where the court has an expert first, the court will almost instinctively rely more heavily on someone it trusts or knows even where that individual lacks appropriate credentials. So, having a therapist testify can also give an important perception that the battered spouse is not seeking to hide behind the shield of confidentiality even where to do so can be done appropriately.

Too often treating therapists of child victims who are asked to testify do not feel they are qualified to testify as an expert because they may not know the

entirety of a case or have a balanced position, or they are confused about the ethical requirement of confidentiality if they render an opinion. To testify does require consent of the client, and balance is not necessary. They must seek and get permission of the client before testifying to otherwise confidential information. But they can then explain why a child, for example may not have told detail of abuse, yet told the therapist during the course of treatment. Or they may be able to explain why a battered spouse never called the police or told a family member about what they were enduring. The therapist ought to be eager to assist in setting forth the issues as they are seen through their eyes only. In doing so they are not only supporting the patient but giving validity in an open and concrete way.

By definition treating therapists are qualified to testify. They don't need to know the whole case. They have an obligation to improve the mental health of their patient and do what is in the patients' best interest. The treating therapist can only be examined by lawyers or the court with regard to issues about which they have sufficient information and expertise. They cannot be



Toby Kleinman, Esq.

challenged as a forensic expert as they are not required to be balanced. They are treating, not evaluating.

What a therapist is treating for, and how they determined what treatment is necessary as a result of what they observe clinically, is important on many levels. First, from an evidentiary standpoint, information gathered during therapy, which is told to a therapist in confidence during treatment by a child or an adult, is assumed to be honest and for the sole purpose of treatment. Thus, this information, when testified to in court by a treating therapist, may be less suspect than the identical information given to an evaluator by the same person, be it a child or an adult.

Secondly, the opinion of a child's therapist with regard to what happened to a child, where child abuse is alleged for example, and where a child has revealed abuse to the therapist, may be the most powerful and persuasive testimony for a court to hear. It is known that children often do not re-disclose the same information twice. Especially young children may believe one adult has communicated the information to the other and they don't tell again. Abuse does not get told by children as a 'story.' The information comes out over a period of time and leaves many unanswered questions. This may be disconcerting or not believed by the untrained psychologist. Therapists become trusted adults in a child's life, and thus may be given more detailed information than a forensic evaluator to whom the child may never disclose the same information in the same amount of detail.

In contrast to the therapist, the forensic evaluator may not have built sufficient rapport. An improperly trained forensic may not recognize the need for more rapport building. They may see disclosures by a child to someone else as lies or the result of coaching when the child has not specifically disclosed this information to them. The therapist, on the other hand, likely knows the child better. In doing what is in the best interest of the client, the therapist is best positioned to speak about the child's disclosures and the likelihood of their being what the child actually experienced, and to give opinions to the court as to the child's level of suffering, or similarly, to speak of a battered wife's descriptions of her experience and why it fits with having been actually battered.

An evaluator may not have been directly told about the abuse by the child. The evaluator may thus have only heard about the disclosures of a child from a second hand source, about whom the evaluator may be skeptical. If the mother is the second-hand source and is also a victim of spouse abuse, forensic evaluators with little or no training may inaccurately attribute expressions of anger or fear to vindictiveness and paranoia rather than recognizing them as symptoms of Posttraumatic Stress. A therapist may opine on these issues directly about their patient, thus negating a poorly done court appointed evaluation's inaccurate findings.

While on the surface the problem for the therapist is revealing confidential information, that is not

different from a forensic evaluator who must tell the person being evaluated that there is no information that can be kept confidential from the court once it is disclosed. Also, especially with domestic violence and child abuse, the most difficult information to disclose may be the most pertinent to disclose in order to gain protection from the court.

Some say that the tools of the forensic evaluator safeguard an evaluation process and may even overcome insufficient credentials of an evaluator. I disagree. These tools include the use of collateral information from a variety of sources other than the individuals being evaluated as well as psychological testing. Evaluators without the requisite knowledge and training cannot weigh the importance of the information they are given nor can they necessarily use proper collateral information or testing, nor are they qualified to interpret the results. Indeed, experience is often used as a counter to training and education. But if they have been doing it wrong for years, no matter how many evaluations have been done, it does not overcome the lack of education and proper training. This means simply that they will continue to do it wrong and risk putting children in harm's way. Thus, unless opposing counsel knows that the code of ethics for psychologists requires the evaluator to have specialized knowledge and training in these areas, the court may never know the evaluator is not qualified. A treating therapist testimony can assist the court in sorting this out.

There are many issues confronting experts in court. But it is critical that therapists be willing to testify as experts to assist their clients, enhance the courts' understanding of the nature of abuse, and help protect children in the courts. There is no dilemma. Their opinions are relevant and may be essential.

Toby Kleinman, Esq. is a New Jersey attorney and a partner in the law firm of Adler & Kleinman and has consulted in legal cases in over forty states. She is an associate editor of *The Journal of Child Custody*, and has published articles in *The New Jersey Law Journal*. Ms. Kleinman has co-taught a class at the *Harvard School of Public Health*. She is a director of the advisory board to the *Leadership Council on Child Abuse and Interpersonal Violence (LC)*, has served as the *Professional Liaison to the APA, Div 56*, and has been voted a *New Jersey Super Lawyer*. She has presented at *IVAT, AFCC, and Battered Mothers Custody Conferences* as an invited Keynote speaker and has trained family court judges. She has lectured at several colleges. Ms. Kleinman is also called as a guest expert on network television, including *Good Morning America* and *World News Tonight*. •

Spotlight on Social Justice - Exploring Work at the Intersection of Trauma Psychology & Social Justice: Call for Contributions!

Amber Douglass, Chair Social Justice Task Force

What is the relationship between trauma psychology and social justice? This is a question that is at the core of the work of the Social Justice Task Force of Division 56 – Trauma Psychology. For many of us working in the trauma field, trauma psychology and social justice are inextricably linked. We believe that in order to be effectively engaged in trauma work, one must simultaneously implement social justice. The practice of trauma psychology overlaps with the practice of social justice when it examines injustices and advocates for marginalized and disenfranchised individuals. For others, the relationship is more present in specific activities, e.g., participating in community-based interventions, dissemination of policy related to trauma psychology, or victim/survivor rights.

We would like to ask division members about the ways they infuse social justice in their trauma work for a section of the Division 56 newsletter highlighting social justice work being conducted by our membership. For example, Sandra Mattar, a member of the Social Justice Task Force, is involved in an active collaboration across APA divisions. In addition to serving Division 56 as its Representative to Council, Sandra also represents it in the Divisions for Social Justice group (DSJ). The DSJ brings together representatives of several APA Divisions with a goal of promoting social justice and equity awareness in psychological science, practice, public policy, education, and APA governance. The recent tragic

events in Norway and the rise of extremist ideology have spurred an initiative among DSJ members to organize APA convention programming focusing on the intersection of trauma, political ideology and social justice. DSJ has also been involved in conversations on the APA's position regarding the participation of psychologists in forced interrogations and torture.

Our hope is to use this section in the newsletter to explore the nature of the relationship between trauma psychology and social justice. To jumpstart a dialogue among members of the division, please consider contributing responses to such questions as:

- How is social justice exemplified in your work as a trauma psychologist?
- How do trauma psychologists become engaged in social justice work?
- What are the barriers to social justice work within the field of trauma psychology (research, teaching, and practice)?
- What are prime examples of work at the intersection of trauma psychology and social justice?
- How do we support each other as we engage in social justice work?
- Is there value in social justice work?



Amber Douglass, Chair Social Justice Task Force

Please be in contact if you would like to share your work on social justice with other division members in the newsletter – Amber Douglas, Chair Social Justice Task Force, adouglass@mtholyoke.edu. •

News from the Division 56 International Committee

Kathryn Norsworthy, Chair

During APA this year, Division 56 was pleased to welcome our Haiti colleagues, Jacques Solon Jean and Roger Noel, who, along with their US collaborator, Leah James, graduate student at the University of Michigan, presented as part of a Division 56 sponsored symposium. They described a model of collaborative post-earthquake trauma work, delivered under the auspices of their organization, *Soulaje Lespri Moun* (SLM; “Relief for the Spirit”). Later in the convention, Solon, Roger, and Leah elaborated on their model and engaged in dialogue in a very well-attended conversation hour sponsored by the Division 56 International Committee. It was indeed a privilege to hear directly from our Haitian colleagues, Roger and Solon, about the situation in Haiti and their perspectives regarding effective trauma response work in their home country. Further, the collaboration among Roger, Solon, and Leah represents a cross-national partnership that consciously seeks to center local worldviews, “psychologies”, knowledge, wisdom, and “ways”, while also integrating western approaches that may be useful within the Haitian context. We requested that Roger, Solon, and Leah provide the following description of their project and ongoing research along with the accompanying photo so that we could share their important work with the larger membership. Many thanks to this team for your work and your willingness to share it with us here. •

Development, Implementation, & Evaluation of a Lay Mental Health Worker Project in Post-Earthquake Haiti

*Leah James, Jacques Solon Jean, Roger Noel, and
Jorge Delva*

Following the massive January 2010 earthquake, millions of Port-au-Prince residents were displaced from their homes. Today, a year and a half after the January 2010 earthquake, hundreds of thousands of Port-au-Prince residents continue to reside in camps for internally displaced peoples (IDP camps) in which securing basic necessities is an ongoing battle. Research conducted by our team and reports published by the World Health

Organization indicate that many IDP camp residents suffer from physical and psychological difficulties such as head and body aches, sleep disruption, hypervigilance, intrusive memories, grief, anger, guilt, isolation, and excessive drug and alcohol use (University of Michigan & Small Arms Survey, 2010; IASC, 2010). Port-au-Prince lacks the infrastructure needed to efficiently provide even basic services to displaced individuals (IASC, 2010; USAID/OFDA, 2011). Since the quake, foreign psychiatrists have assisted by providing emergency services and treating psychotic and other acutely mentally ill individuals. However, for the average resident of IDP camps, access to mental health services is highly unlikely (Sontag, 2010).

Soulaje Lespri Moun (SLM; “Relief for the Spirit”), a lay mental health worker project housed by the Aristide Foundation for Democracy (AFD) in Port-au-Prince, is currently underway in Haiti. SLM was developed through collaboration between Roger Noel (Haitian project manager), Jacques Solon Jean, (Haitian psychology student at the State University of Haiti), and Leah James (University of Michigan doctoral student and PTSD clinic social worker at VA Ann Arbor Healthcare system), with funding from the Aristide Foundation and the University of Michigan Center for Global Health. In April 2010, we teamed with Todd Favorite and Mike Messina (VA Ann Arbor psychologists) to train eight Haitian young people to work as lay mental health workers. Since then, these *Ajan Sante Mantal* (lay mental health workers) have conducted free culturally-tailored seminars with hundreds of residents across seven IDP camps. In each camp, the lay mental health workers run three weekly seminars for one month, using two parallel approaches to promote resilience. First, participants are provided with psychoeducation and trained in coping skills relevant to enhancing perceived safety, ability to self-calm, and social support (Hobfoll et al., 2007). Second, SLM aims to enhance life purpose, meaning, and hope by encouraging workshop graduates to lead their own informal seminars to teach coping skills to new participants. Not only does this model allow for time- and cost-efficient dissemination of information, we predict that reengaging with a traumatizing situation in a prosocial role has therapeutic properties in itself (e.g. Reissman, 1965).

Importantly, we utilize a culturally-sensitive and accepting protocol which reinforces local as well as Western psychological explanatory, coping, and treatment strategies (Argenti-Pillen, 2000; Dudley-Grant & Ethridge, 2008). The co-developers and I have deeply considered concerns that importing a culturally-incongruent approach to explaining and treating disaster-related distress may disrupt local explanatory and healing models. Fundamentally, we propose that when a model is culturally-sensitive and open, people may maintain and benefit from both local and Western perspectives simultaneously, even if these ideas are not entirely congruent. For example, a camp resident

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Ajan Sante Mantal (ay mental health workers) teaching the butterfly hug, a relaxation technique, to residents of a camp for displaced peoples' in Port-au-Prince, Haiti.

International...

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suffering from fear and muscle tension described relief resulting from SLM's "fight or flight response" education paired with relaxation exercises. However, later that week, she reported additional relief following a visit to the voodoo doctor to perform rituals designed to lift a curse.

We have taken a series of steps to encourage such diverse and flexible coping. As described, SLM's train-the-trainer model puts Haitian staff in core development and implementation roles, allowing for the filtering of Western ideas through a local perspective. An ongoing priority is the development of collaborative relationships with religious and traditional healers in order to further cultural adaption. SLM's lay mental health workers are trained to accept and validate a broad range of responses, including not only PTSD symptoms, but also the headaches and other physical responses often described by camp residents, as well as diverse coping mechanisms. Moreover, SLM aims to tap into the therapeutic elements of cultural practices disrupted by the earthquake – for instance, by incorporating the group song, dance, and prayer typical of Haitian festivals. Most fundamentally, in line with Haiti's collectivist social structure, rather than focus on individual psychopathology, we use a group model, framed as a "training seminar" rather than "therapy", which explicitly provides the opportunity to develop

lasting supportive networks and contribute to the community.

In sum, despite being grounded in some tenants of Western psychological science, we see our model as culturally-sensitive and accepting, and thus promoting diverse and effective coping.

In this sense the development and evaluation of SLM speaks to wider controversies within the field of cross-cultural mental health treatment (James, Favorite, Noel, & Jean, under review).

Thus far, our approach appears to be effective. Preliminary data were collected between April 2010 and January 2011 using a range of methodologies tailored to varying levels of chaos and transience in the camp setting. These data show a decrease in PTSD symptoms using the Harvard Trauma Questionnaire and increased coping skills among SLM participants. A parallel hypothesis is that the lay mental health workers will benefit from implementing SLM; indeed, we have observed decreased PTSD symptoms and low levels of compassion fatigue among our Haitian team members.

In January 2011, we conducted interviews with our lay mental health workers regarding distress, functioning, and coping among the camp residents they work with, and trained them to conduct open and closed-ended interviews with eighty-four camp residents across four camps. These data were used for two aims: 1) to assess participant needs one-year post-earthquake



Ajan Sante Mantal (lay mental health workers) presenting a celebratory cake to recent graduates of the Soulaje Lespri Moun (Relief for the Spirit) project.

From left: Merry Roche, Marthe Voltrice Revolve, Gilbert Kenson, Roger Noel (project manager), Ernsou Saul Roche, Louis Jean Roberto Stevenson, Leah James, Soulouque Anderson, and Gloria Germain (not pictured: Farah Charles and Jean Jacques Solon).

so as to guide model revision and contribute to our collaborative development of an SLM program manual; and 2) to inform the development of a tailored measure of distress and functioning to replace PTSD checklists, which can obscure culturally and contextually-specific responses.

Our results revealed that physical symptoms, such as headaches, stomach aches, disrupted menstrual cycle, and increased or decreased sexual functioning, continue to constitute primary complaints in many cases. These symptoms, as well as commonly endorsed emotional responses to trauma and chronic stress, were accordingly integrated into our distress measure. In June, we finalized the manual and instrument, and both are currently being tested in Port-au-Prince. As conditions in the camps have stabilized somewhat and our team has gained experience and confidence in evaluation procedures, we are preparing to conduct a more formal waitlist control group evaluation study using the new assessment instrument and manual to assess outcomes on seminar participants and determine

extent of model adherence. This trial is scheduled to commence in September 2011.

Future aims include adding a parallel model for children; Dr. Todd Favorite, VA psychologist, has visited Haiti twice to conduct preliminary research to develop a story-telling procedure to help children cope with stress and trauma. We are also interested in assessing the particular effects of running support groups for others on SLM graduates. We hypothesize that this opportunity to help others has its own distinct therapeutic benefits, but have not yet been able to conduct research that would allow us to disentangle these effects from those of participating in the psycho-education and coping skills components of the seminars.

If you would like further information about this project, please contact Leah James at leahej@umich.edu, Roger Noel at jrogernoel600@gmail.com, and Solon Jean at jjacquesolon@yahoo.fr. •

Electronic Representations of Your Professional Image: Tips on Creating a Web Presence

Tyson D. Bailey, PsyD

The advent of the Internet has forever changed the way we do just about everything in our society.

These changes have permeated our professional and private lives in more ways than is possible to count. I find it difficult to remember what life was like before it was possible to access information with a click of a button, instead of going to the library and sifting through dusty journals and books. Reflecting on these changes as I traverse the path from graduate student to Early Career Professional (ECP), I realize that I'm faced with a new chapter in the age of electronic and social media: the creation and marketing of a professional image.

Psychologists have many decisions to make during the early parts of their career, regardless of the professional path they take. As I began to think about creating a professional website, I browsed the Internet looking for examples of websites that contained elements I thought matched my desired professional image. Next, came the task of deciding whether to build it myself, use an internet-based resource that would do the work for me, or hire a professional to guide me through the process. Finally came the most difficult part, writing content that would speak directly to those clients I wanted to bring into my clinical practice. This process brought up many questions and concerns, including:

- Who are the people I want to market to?
- How do I create an image that is most likely to attract them?
- How many different sections do I need?
- Do I write my content in first or third person?
- What type of images should I use?

Although my focus is primarily clinical, in speaking with other ECPs, it seems that these concerns are relevant for many of us. We are seeing a marked increase in employers looking at potential candidates' web presence as part of the hiring process – creating a specific need to only have professional, well-controlled information that is publically available.

In an effort to gain more insight into the creating of ethical, effective web presence, I recently interviewed Jill Olkoski, MA and Andy Benjamin, JD, PhD, ABPP, both of whom consider having a web

presence as an important component of the marketing process. Jill Olkoski develops websites for small businesses with a particular emphasis in the mental health fields (<http://aldebaranwebdesign.com/>). Jill holds a Masters degree in clinical psychology, which in combination with a former career in engineering, enables her to produce high quality, client-focused material for the web. Her varied education and experience provide her with a unique perspective on how to effectively communicate about technology to individuals who are not tech-savvy and foster long-term collaborative relationships that bring her website clients new business. Andy Benjamin is an affiliate professor at the University of Washington (UW), where he currently teaches both law and clinical psychology classes. In addition, Dr. Benjamin regularly consults with psychologists on ethics concerns, whether related to therapy, contractual obligations, or electronic media issues. He is also the president-elect for APA's Division 31, and created a program at the UW that trains psychologists in the ethical assessment of high-conflict parenting evaluations.



Tyson D. Bailey, PsyD

1. What are the advantages and disadvantages of having a web presence?

Jill Olkoski: There are no disadvantages in having a website. In fact, as phone books become more obsolete, people are using the Internet as their primary research source. If your business, including a therapy business, doesn't have its own website, people who are searching for your services will find your competition, instead of you. Even if you have a listing in *Psychology Today*, or another similar directory, it doesn't have nearly the impact and comprehensive information that your own website does. The only disadvantage I can think of is that you need to be willing and able to respond to emails in a timely manner. Not all people want to use the phone, so you must be willing to respond to emails if you have a website. Having a website does mean more work for you, but it does mean greater connections with your clients.

The advantages are enormous – your site is your electronic presence, your representation of who you are and what you do. Many folks won't hire a therapist or make a call unless they can read information about their practice. A website for most therapists costs between \$500 and \$2000, so even if the website gets you ONE new client, it's paid for itself – an excellent return on

investment. Websites only cost \$10 a month to keep running. There is no reason a therapist can't afford to have their own website, unless they are completely techno-phobic and won't read emails.

Andy Benjamin: For the generation I work with (the Millennial Generation), it is clear that a higher degree of expectation about easily finding information about me exists. People want to be able to look at the web and quickly understand what services I provide. I find the major disadvantage is the implicit expectation that I will respond immediately. I feel a little pressure to meet this expectation, which I regulate by ensuring I'm responding to folks in a timely manner. I review a lot of information electronically every day, and it can end up taking a lot of time.

2. If you choose to have a web presence, what are the *must have* elements?

Jill Olkoski: You must have four basic pages: Home, About, Service Description, Contact. These are the minimum; many therapists have many more pages that detail different services, talk about appointments and fees, offer forms for downloading, or directions. You must have an email address that's based on the website domain, not on your personal email (do not use Gmail®, or AOL® or Comcast® or Yahoo®, etc.... Use an email address based on the website name). On your contact page, you must have both email address and an online contact form.

Andy Benjamin: Having an email account is an absolute must; however, your disclosure agreement should have explicit language about you not being readily available by email and the limits to confidentiality. I believe Linked In® is a must for any person in the professional services. Facebook® and Twitter® are much more relaxed, but have their uses for allowing colleagues to connect with you. If you use a variety of social media, connect them together and ensure your content is consistent. If I was an ECP, I would consider a website an absolute necessity. I would also write a blog that had relevant, high quality information about my practice area(s) at least once a week. The blog should not exceed two paragraphs in length. You should also insert into each blog at least one URL to another article or blog. The more you interconnect with other authors and blogs, the higher your rankings for search engines, and the easier you are to find.

3. Common mistakes/errors/problems?

Jill Olkoski: They do it themselves using a website builder tool, or they have a friend/relative do it for free. Professionals need to make sure the person they hire is familiar with how to build websites according to Google's quality guidelines and that they understand how search engines work. Make whoever

you hire prove this to you with websites they've done before. Talk to other people who have had their websites for over a year; ask for references. People are often happy when they finish a site, but the real proof of performance is when they are still happy a year later. I hear sad stories from people who have had website developers abandon them, so talking to long-term clients is very important. People should also have a basic understanding of how search engines work. For example, search engines read text; they do not see pictures. So if you want your website to be listed in the search results for *PTSD Philadelphia* then that word had better appear frequently. It's all about the text, the words you use. Learn how search engines work, and then write your content accordingly. You'll be more repetitive than you would in writing normally.

Andy Benjamin: If you do use these electronic media outlets, you must update the information. You should update or modify something at least once a week, such as posting helpful updates on Linked In®, or writing blog articles. I have seen people choose topics for their blogs that are not relevant, or reflect poorly on their professional demeanor, and that makes a difference. You should choose something that is highly visible for your particular field – not something abstract or irrelevant. I also see people not creating a professional persona, which I think is a significant mistake. Consumers of any service expect you to have one, whether they are clients or other professionals. I don't post anything personal; it is too easily misinterpreted and found. For this reason, I recommend that people only use social media for professional connections, and not have a personal Facebook® or Twitter® account. Finally, anything written should be written in a pithy manner, and with good grammar. It seems pretty basic, but I see really good content written so poorly that readers become distracted. As a final note, I tell my students to "make your point and stop," as it is so easy to say too much and lose the reader.

4. Is it possible to make your publications available on your own web page?

Andy Benjamin: It depends on the publisher, but be forceful. You need to make sure you review your contract, and strike out (and initial) any aspect of the contract that would prevent you from reprinting your article on your own website. I also recommend using Academia.edu, as it allows you to easily upload papers and create a professional profile that is readily accessible by the public. However, when considering what papers to upload, you should only use the papers that really will draw the market with whom you want to work.

5. What kind of personal information should and should not be included on a webpage?

Jill Olkoski: This will depend on the theoretical

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Voices from the Classroom:

Dear Mentor

We are excited to bring you the inaugural issue of the “Dear Mentor” column, a joint initiative developed by the students and early career psychologists (ECPs) of Division 56. Students and ECP members are invited to send in their questions about clinical training, trauma research, grant writing, job hunting, etc., that are then answered by more seasoned division members. This column serves to increase communication and resource sharing between members and is a wonderful place to go to for advice! To submit a question, send an email to Jennifer Doran (student) at jenniferdoran718@yahoo.com or Tyson Bailey (ECP) at tdbaileypsyd@gmail.com.

Dear Mentor,

I'm interested in working in trauma but splitting my time between clinical work and research. I hear that this is quite difficult to do, and that one tends to become either a full-time researcher or a full-time clinician. Is that correct? Are there “tips” that psychologists who do this successfully have?

Thanks,

Split-minded in Illinois

Dear *Split-minded in Illinois*,

I am fortunate enough to have found a job that does allow me to do as much clinical work as I want and as much research as I want, so I can certainly give you some tips on how I was able to do that. Now, if only I could invent a machine that stretched time... or could locate that elusive “balance”... or could feel like I had mastery over my clinical and research work or either.... With these things I will not be as much help I am afraid.

My first tip is that the VA Healthcare System can be a great place to be if you are interested in both clinical and research work in trauma. The VA promotes and provides training in the most empirically supported treatments for posttraumatic distress and supports and conducts ongoing research to increase our understanding of risk factors and improve treatment outcomes. It is not surprising, then, that an abundance

of expert trauma clinicians and researchers can work at the VA.

When I started at the VA over five years ago as an intern, I was pleasantly surprised by how ideal an environment it was for me (not having known much about the VA and never really giving it much thought prior to internship applications). And about three years ago I stepped into the position I am currently in, which feels pretty much like it was actually made for me personally. I guess part of that is luck, but I also have to admit that part of it is how much control I have over my vocational destiny as a clinical psychologist at the VA. I was told by several different colleagues that the average length of time it took to carve out the position you want at the VA is two years – they seem to have been correct.

Having said this, I do want to note that not all VAs are created equal. Each may weigh clinical work and research differently. I am just saying the VA is a good place to look into. However, in any setting you are considering working, you should check with your potential employer whether the type of clinical-research position you are hoping for is feasible. Moreover, even if you do find yourself in a setting that does equally value and allow for research and clinical work, it is generally not the case that opportunities just fall from the sky and all you have to do is have your uncluttered lap there waiting for them to fall on. So, my next tip is that you have to be your own best representative and advocate. Keep your ear to the

ground and make connections. Do not be afraid to ask for what you want. If you do not let people know what you want how can they help you get there? Plus, you cannot possibly be aware of all possible opportunities that might come around so you need others to pass along this information when they become privy to it. Also, wherever you are, do a great job. It does not matter how many doors may be in front of you, no-one is going to tell you about them or invite you to knock on them if they do not think you are up to the challenge of what is on the other side of those doors.

Obstacles to successfully splitting your time between clinical and research work may also come from within. If you are in private practice, for example, you may have to sometimes resist the urge to make more money (by seeing clients) rather than reading



Carolyn B. Allard, PhD

the scientific literature or producing research with that time. Also, as I alluded to at the opening, it is difficult to balance the work you do in both capacities because both in-boxes will always be full. Some people find themselves attending to clinical work more readily because there are usually weekly deadlines (appointments), whereas in research one must make and keep one's own deadlines (which are often longer term and come with a longer delay in satisfaction). One key to balancing clinical and research work is to have overlap in those interests when at all possible (e.g., studying the same population that is treated, doing clinical outcome research).

My final tip, which is applicable to attaining a desirable position in general and not specific to a combined clinical-research position, is to keep one eye on the goal and one eye past the goal. If you have the goal in sight, you can keep moving toward it. If you also look past the goal, you might find other paths to your goal or other goals altogether that you had not considered before.

Good luck and happy trails!

Carolyn B. Allard, PhD
Assistant Professor, Department of Psychiatry
University of California, San Diego
Director, Military Sexual Trauma Program
VA San Diego Healthcare System

Note: I wish to thank Dr. Steven Thorp, who is also a trauma clinician and researcher at the VA San Diego Healthcare System, for some of the helpful suggestions he shared with me that I incorporated into my response. •

“Three things in human life are important. The first is to be kind. The second is to be kind. And the third is to be kind.”

Henry James

Early Career Web Presence Tips...

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orientation of the therapist. Psychoanalytic folks discuss very little, where as other orientations discuss more. For a therapist, I think personal disclosure should be in the service of the client. Your website is about helping them decide to hire you, so provide them with what they need to know to make that decision. Remember, what you put on a website lives forever, even if the site is taken down. You should always put your picture there, and this is a major sticking point for many therapists. People want to know what you look like, even if you don't like having your picture taken.

Andy Benjamin: I've heard people say no pictures, but I think we are a visual culture, and that it's really important for people to be able to see you. I do not think any other personal information should be available that is not directly related to people contacting you for professional roles. People should be able to find information relevant to their concerns, such as services that can be rendered, or a CV.

In a time where so many people are competing for employment or to make a living, establishing a web presence that is most likely to facilitate those goals is critical. I would like to thank Jill Olkoski and Andy Benjamin for their insights into these issues, as well as the time and energy they put into discussing their thoughts with me. As a final note, it is important to remember that a website is only one small part of the marketing process. It is critical to create your professional image and write high quality content before putting together any form of web content. Websites should speak directly to the clients or employment opportunities you want to have; therefore, it is crucial that you know what/who they are before you begin the process of putting yourself on the Internet.

Website Resources:

APA Career Development:

<http://www.apa.org/careers/resources/index.aspx>

APA Practice Organization:

<http://www.apapracticecentral.org/>

Jill Olkoski's Blog: <http://aldebaranwebdesign.com/blog/>

Mike Langlois', LICSW Website: <http://gametherapist.com/blog>

<http://Academia.edu>

<http://Linkedin.com>

Tyson D. Bailey received his doctorate in clinical psychology from Argosy University, Seattle, and is currently a postdoctoral fellow at the Fremont Community Therapy Project, Seattle. His clinical work focuses on the treatment and assessment of posttraumatic reactions. He is a member of the Division 56 Taskforce on the Assessment of Trauma Sequelae and heads the Div 56 ECP publications subcommittee. •

New Division 56 Fellow



Dr. Thomas Demaria received his PhD in Clinical/School Psychology from Hofstra University in 1986 and has over twenty years of hospital behavioral healthcare leadership experience including the management of inpatient psychiatric and behavioral medicine consultation services and outpatient mental health and substance abuse programs. He is now the Director of the Psychological Services Center in the Doctoral Psychology Program at C.W. Post (Long Island University) and founder of the Student Trauma Response Team. Dr. Demaria serves on the Professional Advisory Board for the National Center for School Crisis & Bereavement and is a member of the strategy group on Trauma Affecting Women & Children for Region II of the United States Department of Health & Human Services. Dr. Demaria has earned numerous awards following

local, national and international community disaster counseling responses during the past twenty years. He is a two time recipient of the prestigious New York State Liberty Award for community service in New York following the World Trade Center terrorist attacks and in the Gulf Coast following Hurricane Katrina. In 2004, Dr. Demaria was presented a Humanitarian Award by the Center for Christian & Jewish studies for work with Holocaust Survivors. In 2005, Dr. Demaria was co-recipient of International Society for Traumatic Stress Studies' Sarah Haley Award for Clinical Excellence. When not working, Dr. Demaria enjoys spending time with his family, antiquing and studying the American Civil War. He believes that providing community disaster mental health services and receiving ongoing mentoring were key factors in his development as a trauma psychologist. •

Division Fellow Applications

We invite and encourage individuals who have shown evidence of unusual and outstanding contributions or performance in the field of trauma psychology to apply for Fellowship status within Division 56. You must be an APA member for one year, and a member of Division 56. APA members who are not yet Fellows of any APA division must meet APA Fellow criteria, apply for Fellow Status according to APA procedures, and complete the APA forms, all described at: <http://www.apa.org/membership/Fellows/index.aspx>. This year, the Division deadline is December 1, 2011 for applications to be received by our Fellows committee chair, Laurie Pearlman (lpearlmanphd@comcast.net). Division members who are current Fellows in other divisions are welcome to apply at any time. Please contact Laurie for information about the process.

Spring 2012 TPN Call for Articles



Ruth A. Blizzard

The Trauma Psychology Newsletter is accepting articles related to trauma psychology for the Spring 2012 issue. The focus may be theory, research, clinical or community applications, education and training, or policy. Deadline: February 15. Length 1,500–2,000 words, in MS Word or WordPerfect formats. Include 100 word author bio and photo (jpg or tiff). Submit to Ruth A. Blizzard, PhD, Editor, at info@ruthblizard.com.

Who's Who: Martha Banks, PhD



Martha Banks PhD

What is your current occupation?

I am a research neuropsychologist. My research focus is traumatic brain injuries sustained by women victims of intimate partner violence. I am co-founder and co-owner of a research company that develops tests, including the *Ackerman-Banks Neuropsychological Rehabilitation Battery*®, and provides computer consultation, training, and data analysis for health professionals.

Where were you educated?

I received my AB in psychology from Brown University and my MA and PhD in clinical psychology from the University of Rhode Island. My clinical psychology internship was at the Des Moines Child Guidance Center. In 2010, I received a President's Distinguished Achievement Award from the University of Rhode Island.

Why did you choose this field?

As an undergraduate, I was impressed with the breadth of opportunities in psychology. The introductory psychology course was team taught by most members of the department, so each brought enthusiasm about her or his specialty to the classes. Between college and graduate school, I worked as a computer programmer using SPSS for a research project; I was able to provide training in SPSS during graduate school. I worked in the Veterans Administration for many years, then "retired" to focus on research, writing, and teaching.

What is most rewarding about this work for you?

In addition to my work with trauma in Division 56, I have served in a variety of roles in APA governance, including president of the Society for the Psychology of Women (APA Division 35), APA Council Representative (representing Divisions 35 and 45), and member and/or chair of APA boards and committees (Board for the Advancement of Psychology in the Public Interest, Committee on Ethnic Minority Affairs, Committee on Women in Psychology, and Committee on APA/Division Relations). In addition, I am frequently invited to edit and publish. Publishing and governance service have given me opportunities to provide input based on my wide experience to shaping the future of psychology.

What is most frustrating about your work?

I find that psychology continues to have barriers to full inclusion. My current focus is on Women with Disabilities, but I am aware that advancement in the field continues to be limited for members of all marginalized groups. My own work which spans neuropsychology, feminist psychology, ethnic psychology, trauma psychology, rehabilitation psychology, and family psychology is unique in its intersectionality; as an African American woman, however, I am still greeted with skepticism.

How do you keep your life in balance (i.e., what are your hobbies)?

My team sport is singing; I am an alto in the Akron Symphony Chorus. I love to knit and surprise people. I don't have as many vacations as I would like, but I like to create unusual vacations for myself, my family, and my friends. For the past year, I have found ways to become more involved in my religion and integrate my professional life with my religious life. As a newly trained United Methodist Lay Speaker, I have been given the opportunity to preach about disability (following which my church renovated its sanctuary to accommodate people using wheelchairs and walkers) and provide church-based and church-funded workshops on domestic violence.

What are your future plans?

I am investigating more ways to improve communication about domestic violence through community education and workshops with clergy, the justice system, and health professionals. •

Mendelsohn, M., Herman, J.L., Schatzow, E., Coco, M., Kallivayalil, D., & Levitan, J. (2011). *The trauma recovery group: A guide for practitioners*. New York: The Guilford Press. (193 pp). ISBN 978-1-60918-057-7. \$35.00.

Karin E. Thompson, PhD

Survivors of childhood trauma and interpersonal violence (IPV) often have significant struggles with recovery from posttraumatic stress disorder (PTSD) and other trauma-related disorders. “Complex PTSD” is a concept developed in 1992 by Judith Herman that refers to a myriad of difficulties faced by these survivors. The authors of *The trauma recovery group: A guide for practitioners* bring to bear their substantial clinical experience, firmly grounded in theory and supported by research, to develop the group intervention described in this well-written, thorough treatment manual.

Based on a feminist perspective and understanding of IPV, the authors point out that women and girls are more likely to be victims of such violence (e.g., rape, sexual abuse, physical abuse), and perpetrators are more likely to be men. This context is important not only as a guiding theory for their treatment and a framework for its development (originally developed for female survivors of child sexual abuse at Harvard Medical School’s Victims of Violence Program), but also as an active psychoeducational component of the group. Members are helped to make sense of their experience by understanding their personal trauma in the broader context of male expressions of power that perpetuate the subordination of women. The authors, who devote substantial time to this idea in the first chapter, provide a compelling and thought-provoking review and rationale for applying feminist principles to recovery from IPV. Feminism is described as simply an extension of human egalitarianism to the condition of women, challenging hierarchical social structures whether they are based on gender or other factors such as race, religion, or class.

PTSD practitioners and trauma specialists will enjoy reading the thorough literature review covering the prevalence and impact of IPV and the psychotherapeutic treatments that have been developed to treat the sequelae of interpersonal trauma. We are reminded that IPV is alarmingly widespread. Most people seeking treatment for severe mental illness are survivors of IPV. The authors provide a review of the concept of complex trauma, noting that when interpersonal trauma occurs repeatedly and over the course of a lifetime, the impact can be extensive and enduring, leading to disturbances of personality and emotional regulation that go beyond simple PTSD.

Survivors of IPV benefit from a stage-based model of treatment. Based on Herman’s pivotal work

(1992), the authors summarize the stages of recovery, providing a compelling framework for thinking about the treatment needs of many trauma survivors. The first chapter of the book is excellent reading for anyone in the field of PTSD treatment as it summarizes theory and research and provides a framework for understanding complex PTSD from which even the most active and seasoned clinicians can benefit.

Although there are many treatments currently available for PTSD and considerable evidence in favor of individual psychotherapies, the authors provide a compelling rationale for a group psychotherapy approach and explicate its power and applicability for survivors of IPV. In particular, when survivors of similar traumas come together in a group setting, they gain a broader perspective of their experience, recognizing that others have suffered experiences similar to their own, and that this can be understood in the context of a broader social milieu extending beyond any individual experience. Group psychotherapy provides the added benefit of reducing isolation, secrecy, and stigma, allowing survivors to connect with other people, a common disturbance in functioning for many individuals with complex PTSD. Although current research does not support any particular group psychotherapy approach, it does suggest that group psychotherapy for trauma survivors is associated with a range of favorable outcomes.

The Trauma Recovery Group (TRG) described in this manual is a Stage 2 trauma-focused group. Individuals who may benefit have completed Stage 1 recovery (establishment of safety; development of coping skills) and are ready to move to the next stage with a focus on remembrance, mourning, and integration. Chapter Two provides a detailed overview of the sixteen-week TRG. The following four chapters describe the specific techniques and strategies of this group, including preparation and screening of potential members. The authors are very thorough throughout this manual in a way that clinicians will find pleasing and reassuring. The clarity and specificity with which theory, goals, key elements, and client/therapist requirements are presented is impressive. TRG clinicians must be familiar with complex trauma and recovery as well as the basics of group psychotherapy. Clients who can benefit must be identified through a thorough screening, with criteria including stability in trauma-related symptoms; no self-harming behavior, hospitalizations or substance abuse over preceding year; and engagement in concurrent individual psychotherapy. Recommended group size is five to eight members who have relatively homogenous trauma histories. Facilitators must have regular access to supervision or consultation throughout the course of the group. While these requirements may not always be feasible in many clinical settings, they are sound recommendations and are worth striving for.

The authors provide considerable detail on each of the TRG’s three phases: introductory, goal-work, and concluding. The reader is left with a thorough understanding of the group process and techniques and

the sense that one could implement TRG based on the reading of this manual. Helpful tools are provided throughout, including summary tables, handy forms, and illustrative case examples. Many of the guidelines for TRG are applicable for any PTSD group. Indeed, PTSD clinicians accustomed to providing trauma-focus group treatment will recognize many of the strategies and techniques used in the manual. A unique aspect of TRG is that members select one goal related to the impact of trauma on their current life that becomes the focus of their therapeutic work over the course of the group. The initial sessions are focused on goal formulation, and the goal-work sessions involve sharing traumatic experiences (to contextualize the goal), with time being divided each week among group members. Focus is not on the dynamics of the group process, but rather the goal, including giving and receiving specific goal-related feedback. The authors provide a helpful section on how to define goals so that they are realistic and achievable, trauma-related, concrete, and specific. Clinicians will find the case examples very useful in illustrating the process of goal refinement. The “Common Challenges” section of the goal-work chapter is very well done and comprehensive, providing good strategies and information for trauma-focus work. It is clear that the authors are thoughtful and experienced clinicians.

The latter chapters of the manual describe termination; supervision; adaptation to other treatment populations; and TRG outcome research. Termination of psychotherapy with a trauma survivor is a crucial piece of the therapeutic work given the significant losses and difficulties with trust these individuals have endured. Case examples and discussion are used to illustrate the attention that is given to closure and termination. Members reflect on their own progress toward their goals and receive feedback from other members and leaders. The termination process is described as a “gift” to each member, and the strategies used during this phase of treatment are clearly designed to facilitate this, focusing on the progress of each member and celebrating each person’s progress within the group.

The authors devote the final chapter to describing two prospective studies of the TRG, including one in which it is compared to a psychoeducational group. Also presented are qualitative data based on narrative interviews with TRG participants. Symptomatic improvements and increased capacity for affect regulation as well as a decrease in interpersonal problems and conflicts were observed in TRG participants.

The trauma recovery group: A guide for practitioners is a thorough, well-written, comprehensive treatment manual describing a time-limited, trauma-focused group intervention for survivors of interpersonal violence and complex PTSD. Clinicians in the field of trauma treatment will appreciate the authors’ thoroughness and sensitivity and will be inspired to try this treatment approach.



Karin E. Thompson, PhD, is a clinical psychologist at the Michael E. DeBakey Veterans Affairs Medical Center, Houston, and clinical associate professor at

Baylor College of Medicine, Menninger Department of Psychiatry and Behavioral Sciences. She serves as Trauma Recovery Program Director and national training consultant for the VA Prolonged Exposure Dissemination Initiative. •

Thompson, K. E., & Franklin, C. L. (2010). *The posttraumatic insomnia workbook: A step-by step program for overcoming sleep problems after trauma*. Oakland, CA: New Harbinger Publications. (179 pp). ISBN-13: 978-1-57224-893-9. \$21.95. [paperback]

Rachael M. Swopes, MA and Joanne L. Davis, PhD

The overall purpose of *The posttraumatic insomnia workbook: A step-by-step program for overcoming sleep problems after trauma (The PTSD Workbook)* is to offer a packaged approach for the treatment of trauma-related sleep problems. *The PTSD Workbook* offers a contribution to the current literature by packaging several evidence-based techniques into a manualized format readily accessible to clinicians. As sleep problems are common symptoms following trauma (Krakow et al., 2007), this book may be useful in working with survivors of trauma whether or not PTSD is present.

The PTSD Workbook will assist clinicians to help their clients overcome sleep problems following a trauma. Each chapter begins with objectives to help the reader remain focused and ends with homework designed to match the goals. Most chapters include a vignette, which brings the concepts to life by applying them to real-world settings, as well as tips on how to include a significant other in the treatment process. Symptom logs and questionnaires are included to help the reader track his or her progress through the program. These user-friendly worksheets may make homework easier to complete and may also increase compliance. In order for clinicians to choose what works best for them, the book provides multiple ways to accomplish the stated objectives such as offering several different breathing techniques for teaching controlled breathing. There is also a strong emphasis on self-assessment throughout *The PTSD Workbook*. Ongoing assessments can help clients chart their progress and may help the client and clinician identify challenges so that additional assistance or strategies may be pursued.

Book Reviews...

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Form templates are provided for clients to track changes in symptoms and sleep characteristics over time.

The *PTSD Workbook* provides adequate scientific references to support statements of findings in general, but some sections lack sufficient data and would benefit from additional explanation of the evidence behind the methods being used (e.g., the discussion of ways to cope with nightmares). This is considered especially important for clinicians who may wish to access original sources regarding specific approaches. Furthermore, although the cognitive-behavioral techniques included in the *PTSD Workbook* are supported by research, there is no research described in the book to support the efficacy of the complete treatment package.

The disorders that the book is intended to treat are also unclear. The authors state very clearly in the introduction that the book should only be used to treat trauma-related insomnia, but then in later sections describe techniques to help with symptoms that can present unrelated to insomnia such as nightmares and chronic pain. The authors emphasize the importance of getting additional help for psychological disorders, such as PTSD, depression, and substance use, as these are beyond the scope of the treatment being offered in the book. However, it may be difficult for clients to confront their nightmares without bringing up traumatic memories. Some techniques used in the book, such as journaling and writing out the nightmare, may temporarily cause increased distress and thus may be best done while under the care of a mental health professional.

The book includes an interesting section on hypervigilance in the bedroom, focusing on the heightened sense of danger that some people experience that can interfere with sleep. Specifically, there is a special section on the effects of keeping weapons in the bedroom with a useful checklist for deciding whether removing them would provide restorative benefits. A later chapter takes on sleep myths and provides solid psychoeducation on the facts; however, this area would have benefited from the inclusion of additional references in support of the authors' contentions. They also provide information on the importance of the sleep cycle and how damaging disrupted sleep can be in one's life.

PTSD Workbook describes a useful approach to combat repetitive nightmares, but it does not address when individuals experience nightmares that have similar underlying themes with changes to specific content only. Other treatments have found no differences in treatment response due to type of nightmare, including those that began before the traumatic event occurred but may have been exacerbated in intensity or frequency following post-event (Davis & Wright, 2007).

Finally, one of the biggest weaknesses of this book as a self-help book is the lack of direction on how to integrate the various techniques offered. As each chapter describes a new approach, it is unclear if the reader is to continue previously-described techniques and work in a cumulative fashion or to focus singularly on each new technique as it is presented. In addition, some of the techniques, such as sleep scheduling and cognitive restructuring, may be too complicated for a lay person to implement independently. Some strategies require a high level of insight, such as the change forms included in the treatment motivation chapter. Therefore, we recommend that the book be used by clinicians as part of a manualized treatment approach instead of as a self-help manual. In this context, the clinician and client can problem-solve as to how to integrate the techniques most effectively with the mental health professional overseeing and further investigating their efficacy. In the office of a therapist, it may offer much needed assistance in treating trauma-related insomnia.

References:

- Davis, J. L. & Wright, D. C. (2007). Randomized clinical trial for treatment of chronic nightmares in trauma-exposed adults. *Journal of Traumatic Stress, 20*, 123-133.
- Krakow, B., Haynes, P.L., Warner, T.D., Melendrez, D., Sisley, B.N., Johnston, L., et al. (2007). Clinical sleep disorder profiles in a large sample of trauma survivors: An interdisciplinary view of posttraumatic sleep disturbance. *Sleep and Hypnosis, 9*, 6-15.

Rachael M. Swopes holds a master's degree in clinical psychology and is currently pursuing her doctoral degree at the University of Tulsa. Her interests focus broadly on researching the effectiveness of trauma-focused interventions. She is also interested in the effects of trauma on subsequent risky behaviors as well as in identifying predictors of PTSD in survivors of sexual assault and other interpersonal violence.



Joanne L. Davis, PhD is an Associate Professor of Clinical Psychology and Co-Director of the Tulsa Institute of Trauma, Abuse, & Neglect at the University of Tulsa. Her research interests include the assessment, treatment, and prevention of interpersonal violence and its effects. In recent years she has focused on the assessment and treatment of chronic nightmares and other sleep disturbances. •

Report from the APA Council of Representatives Annual Meeting at Convention

Joan M. Cook, PhD and Sandra Mattar, PsyD

As anyone who has ever attended an APA Council of Representatives meeting can attest to, there is always a lot going on. We share a few highlights with you below. At this year's Annual Convention in Washington DC, Council approved \$2.1 million to fund seven initiatives to advance APA's new strategic plan. These goals include maximizing organizational effectiveness, expanding psychology's role in advancing health and increasing the recognition of psychology as a STEM (Science, Technology, Engineering, and Mathematics) science. Although a more detailed explanation of the plan will appear in the APA Monitor, there are two areas that deserve particular mention. One is the analysis of psychology's work force and the other is an expansion of the Association's public education campaign. We will keep you posted on these endeavors and hopefully we can all participate in the public education campaign, including increasing recognition of trauma psychology.

APA as well as APA's Practice Organization briefly elaborated on their plan to expand psychology's role in advancing health. Namely, they are committed to helping key legislators, health care systems and the general public to recognize the unique benefits psychology provides to health and wellness and to ensuring that psychology becomes more fully incorporated into health research and delivery systems. Among other things, they have advocated for the inclusion of psychologists in integrated health care models, engaged in outreach to state psychological associations for health reform, lobbied effectively for expanded coverage for mental and behavioral health services, and advocated successfully for the recognition and adequate compensation for psychologists in Medicare. In addition, APA continues to develop and promote educational opportunities through its continuing education programming for practitioners to learn new skills to advance their role in health as well as address business of practice issues. In fact, at this year's Convention, Division 56's workshop, "What Every Provider Needs to Know about Working with Adult Trauma Survivors" was recorded and will soon be placed on the APA website for continuing education credit.

Council approved Guidelines for Forensic Psychology for those specializing in forensic work and others, on their roles and responsibilities when testifying in court or sharing psychological expertise before judicial, legislative and administrative bodies. The guidelines will be posted online soon at: <http://www.apa.org/practice/guidelines/index.aspx>

Importantly, Council approved plans to streamline programming during the Annual Meeting. After careful analysis and outside consultation, a

key working group, including a past and an incoming president of APA, explained that many sessions at Convention are not well attended. In order to increase member engagement, in 2014, the Convention hours will be streamlined. That means that every division will see a reduction in programming hours. Although this may be disappointing to some, Council ultimately came to view this as an issue in quality versus quantity and an opportunity to engage in more thematic and collaborative programming with fewer competing sessions. In addition if these programming changes are maintained after a three year trial period, this will increase the pool of cities where the APA convention can take place.

Dr. Geoffrey Reed, an American trained clinical psychologist, who is now a Senior Project Officer of the World Health Organization presented information to Council on the development of the International Classification of Diseases (ICD) 11th Revision. In general, he spoke about the clinical utility and global applicability of this classification system and how psychology is well represented in regards to participation in the revision.

Margaret Byrd, Director of APA's Disaster Response Network, a group of licensed psychologists with training in disaster response who offer volunteer assistance to relief workers and survivors in the aftermath of disasters, spoke to Council regarding the Network and its 20th anniversary. The Network members also engage in a broad range of disaster preparedness and recovery activities from teaching courses on disaster mental health to educating the public about reactions to trauma and ways to manage distress. The Network is growing strong at 3,000+ members.

APA's President, Dr. Melba Vasquez awarded a presidential citation to Dr. Barbara Van Dahlen, founder of the "Give an Hour." Dr. Van Dahlen started this nonprofit organization in order to create a network of licensed mental health professionals nationwide to donate an hour of their time each week to provide free mental health services to military personnel and their families.

In addition, one more major highlight of Council was the announcement of a presidential citation to Dr. Laura Brown, our Division 56. The citation partly read: "For her visionary and highly effective leadership in promoting feminist psychology, lesbian and gay issues, trauma treatment, multicultural competence, psychological assessment and ethics in psychotherapy." Way to go Laura!

During our tenure, we hope to ensure that trauma psychology is well represented in Council discussions, Task Forces, and Committees. If you have any questions or concerns, please feel free to contact us: Joan.Cook@yale.edu or sm26@stmarys-ca.edu. •

Presidential Voice: Remembrance and Re-building: Lessons of Trauma...

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Judith Lewis Herman, PhD, Lifetime Achievement in the Field of Trauma Psychology

Judith Pizarro Anderson, PhD, Outstanding Early Career Achievement in Trauma Psychology

Denise H. Sandole, PsyD, Outstanding Dissertation in the Field of Trauma Psychology

Robert A. Geffner, PhD, ABPP, Presidential Award

J. Christopher Collier, PsyD, Presidential Award

Three Fellows were also honored:

Tom DeMaria, PhD

Roxanne Cohen Silver, PhD

Patricia Dass-Brailsford, EdD

Many thanks to our hard-working Awards Committee, chaired this year by **Dawn Hughes** and the Fellows Committee by **Laurie Pearlman**. We also had a successful fundraiser/book auction at the social, ably organized by **Sue Connor**.

We covered many issues at the Executive Council (EC) meeting that were later reported to the membership at the Business Meeting. Both activities were well-organized by our Secretary, **Kathy Kendall-Tackett**. Among the most noteworthy items from the EC meeting: The Division is on excellent financial footing, thanks to income from membership, the newsletter going green and online, and the success of our journal. **Beth Rom-Rymer** does an exemplary job managing our financial interests.

The Division journal, *Psychological Trauma: Theory, Research, Practice & Policy*, edited by **Steve Gold** has grown significantly in its three years of publication, so much so that it will go to six issues next year (up from four), and the EC voted to pay for an additional 100 pages for the last issue of this volume and the first of next to publish some of the articles that have unfortunately been backlogged. APA Publications has been and continues to be very supportive of the journal and are thrilled by its rapid growth and its significance. **Ruth Blizard** has been instrumental in the ongoing success of our Division newsletter that continues to expand in terms of content and influence.

Laura Brown serves in her usual many roles. Currently, she is working to complete the Division Policies and Procedures Manual (she is still seeking feedback and comments) and continues as Webmaster, along with **Lynn Brem**, of our outstanding web site. Laura also chaired the nominations committee in her role as past president. By-law changes have been suggested and will be put before the membership for a

vote in the near future. **Kathryn Norsworthy**, chair of the International Committee, organized the sponsorship of speakers from Haiti and also prepared a mural of countries where Division 56 members have worked or have affiliations – a most impressive project.

Joan Cook and **Elana Newman** have been active in preparing proposals and seeking funds for a conference on trauma competencies. **Anne DePrince** and **Elana** just co-edited a special section of the journal on trauma education and training in undergraduate and graduate contexts - well worth the read. **Anne** and **Ann Chu** are the co-editors of a new monograph series on trauma topics under development with APA Publications.

Bethany Brand and **Constance Dalenberg** of the Practice Committee are involved in assessment guidelines and a best practices project for the treatment of complex trauma. Additionally, **Constance** is working on collaborative projects with other divisions and organizations and is our President-Elect, Elect, scheduled to begin her term in 2013. Retired family court judge **Irene Sullivan, Esq.** joined the EC as a professional Member at Large. Division 56 representatives to the APA Council of Representative are **Joan Cook** and **Sandra Mattar**, who reported on APA-wide activities and initiatives. This year's include continued attention to health care and Medicare issues and changes in the APA convention, starting with the 2013 convention in Hawaii.

These various activities are only the highlights from a very busy division. How do you get more involved? Contact committee chairs and EC members whose addresses and phone numbers are listed in this newsletter and volunteer for activities. Join a SIG. Write an article or edit copy for the newsletter. Nominate yourself or someone else for an APA committee or an APA grant or award. Contact incoming president **Terry Keane** who is already making plans for next year's initiatives and activities.

Remembrance & Re-building

Division 56 co-sponsored a special panel on the 10th anniversary of 9/11, organized by Sharon Brennan of New York City. Participants included architect, Tom Hennes; New York City psychologists, Billie Pivnick, and Mark Sossin; and Washington DC psychologist/discussants, Jeffrey Jay and Chris Courtois. Mr. Hennes is the architect of the 9/11 site museum, set to open on 9/11/12; and Dr. Pivnick has served as a psychological consultant to the development of the physical plans. They reported on their mutual efforts to develop and design a museum that attends to remembrance and memorialization in response to the shared trauma of 9/11. Dr. Sossin reported on an innovative intervention he designed with other New York City researchers for women who were

pregnant when their husbands perished in the attack. Specialized groups and interventions were designed for these women and their children to help them grieve, memorialize, and develop. Dr. Jay commented on the attack on the Pentagon and the memorials in Washington, especially the Viet Nam Memorial and the Holocaust Museum, and their roles in relevance to the discussion of memorializing tragedy. Dr. Courtois commented on the application of trauma theory and knowledge in understanding this shared trauma and the wealth of information generated in the aftermath of the attack.

In this column, I want to briefly expand on those comments, particularly on the applicability of the lessons of 9/11 to the trauma field and vice versa. We have learned much in the decade since the terror attack, and we have changed as a nation and as a society. Some of the “lessons learned” have to do with the modification and application of some of our techniques, especially regarding early intervention. We have learned to be less active in providing formal mental health oriented interventions (broadly defined here) and instead to offer “psychological first aid” that emphasizes physical and emotional safety, food and shelter, connection and concern, community response, and a return to relative (although vastly changed) normalcy as soon as possible in the immediate aftermath. Education and information have been found to be especially important early on, as is assistance with practical matters and resources. In the acute aftermath, some individuals benefit from talking about their experiences while others do not and should not be pushed to discuss their experiences before they are ready and able to. The population turned out to be far more resilient and to have less PTSD, depression, and anxiety than many trauma experts anticipated. Although, of course, a significant percentage of victims and first responders did suffer from devastating emotional wounds and losses. Rates of PTSD on average were in the 10% range for first responders and less for the general population, but there are vast differences based on the individual’s degree of exposure and numerous other factors.

The 10th anniversary of 9/11 was marked by the opening of the Remembrance Plaza and waterfalls in New York City and other commemorative activities in Washington DC and Shanksville, Pennsylvania. All three were designed for remembrance and memorialization, but this year also emphasized resilience, re-birth, and transformation. A new, taller, tower is under construction over the site of the New York City Memorial Plaza and the future museum. There, visitors are encouraged to reflect and to use the site as a place to gain new perspectives on a shared trauma in a communal setting. Visitors to the museum will be able to approach the tragedy in a variety of ways, from those that are organized toward providing information and engage in cognitive processes, to others that are more personally and emotionally engaging. Part of the museum will be interactive,

allowing visitors to record their impressions and comments and to see them visualized and incorporated with those of others.

Many trauma professionals have been involved in the reconstruction efforts – some of these on individual bases and some (such as the efforts of Drs. Pivnick, Brennan, and Sossin) on communal and memorial projects and activities where they have applied their expertise and sought ways to relieve victims and others of their burdens and suffering. They have also learned from those who were directly and indirectly traumatized, that transformation and healing is possible, even from the most severe of insults and outrages. The lessons of 9/11 also involve new life and re-building. A poignant reminder is the “survivor tree” found deep underground and rescued from “the pit.” With tender care and attention this tree has grown and returned to life, new branches and leaves growing out of gnarly scars caused by the physical trauma. The gnarls are now part of the tree but so is the new growth. The tree has been placed prominently on the Memorial Plaza, a symbol of the site and all it represents.

For trauma professionals, as for victims and survivors, the message is that growth and re-birth are possible, even from terrible damage and bleakness. Healing is often times a slow process, but one that is supported by empathy and response, along with remembrance and incorporation. The ability to make sense, find personal meaning and develop a coherent narrative spring from the opportunities for reminiscence and communal response and concern. Per architect Hennes, the collapsed space of the building and its re-construction and ongoing transformation provide opportunities and metaphors for new growth and new meaning. In my previous column, I discussed the importance of hope to trauma survivors and to their recovery. That, too, is a crucial element that must be added or elicited to spur the growth of possibilities for action. •

Division 56 Endorses

Doug Haldeman for APA President

At its August meeting the Division 56 Executive Committee voted to give our endorsement to Division Fellow and charter member Doug Haldeman. Please give him your #1 vote in the APA presidential election, which closes on October 31, 2011.

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² Inflation Safeguard offers additional insurance coverage and the premium will be added to your bill.

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.
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- 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 subscribe to receive this journal; just be sure that your dues are paid, and your mailing address is up to date.
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Authors' Submission Deadline	Issue	Publication Date
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April 15, 2012	Spring/Summer 2012	May 2012

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