

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

A View Inside

Special Section: History and Development of Trauma Treatments

Retrospective View on the History of Diagnosis of PTSD and Our Evolving Understanding of How Best to Treat Individuals..... 5

The Evolving Conceptualization and Treatment of PTSD: A Very Brief History..... 7

Cognitive Processing Therapy 11

A Brief (Not Prolonged) History of Prolonged Exposure Therapy for PTSD..... 14

Dissemination of EBTs for PTSD: Past and Future 17

Legal Affairs

Custody Evaluations, Therapy Appointments by the Court, Child Protection and Ethics. 22

Early Career Psychologists

Sub-Threshold Traumas Hurt Too; Looking Through the Lens of Reproductive Medical Trauma..... 25

International Committee

Interview With Justin Kenardy, PhD 28

Student Spotlight

Stuck in Transition: A Personal Account of the Cultural Heritage of Trauma..... 30

Who's Who

Heidi Kraft, PhD 33

Division News

Get to Know the Division 56 Award Winners..... 35

New Fellows: Monson and Cook 40

APA Council of Representatives: February 2013 Report 41

APA Council of Representatives: August 2013 Report 41

Trauma Research and the Institutional Review Board, Executive Committee, Division 56, June 15, 2013 43

Opinion

Psychologists Caught in the Line of Fire: How Safe Is the NY SAFE Act?..... 49

NEWSLETTER

Presidential Voice

Constance Dalenberg, PhD

Being President of the APA Trauma Division has its rewards and its burdens, but I have to say that getting the job on the year that our annual convention is in Hawaii was clearly in the rewards category. A fair number of our Executive Committee and many of you who are working hard as members of the division brought your spouses and families with you to the meeting and mixed business with pleasure. I know I came back with multicolored feet from all of the walking I did on the beaches after the convention in my new sandals. True, we began with a bit of a scare when the tropical storms were keeping flights from landing on time, but most of the presenters and EC members made it through. After that, the weather couldn't have been more perfect.

We learned early on at the August convention that Kathleen Kendall-Tackett will play a large role in our Division's future. She will take over the editorship of *Psychological Trauma* from Steve Gold in January 2014, and will be our next President for our Washington conference in August 2014. We learned that our impact factor for *Psychological Trauma* is continuing to rise, moving from .89 (ranking of 80 of 110 in the category for clinical psychology, regarded as a good showing for a new journal) to 1.46 (a ranking of 63rd of 114 journals—close to the mean and rising). This is an astounding accomplishment for Dr. Gold and should encourage all of us to send our best manuscripts to this journal. My own associate editorship winds up this year. After that, feel free to send me your manuscripts for a quick look if you wish for some unofficial thoughts on strengthening it for submission to PT.



Constance Dalenberg, PhD

Officers

President

Constance Dalenberg, Ph.D.
Alliant International University
Email: cdalenberg2@alliant.edu

Past-President

Terry Keane, Ph.D.
VA Boston Healthcare System
Email: terry.keane@va.gov

President-Elect

Kathleen Kendall-Tackett, Ph.D., IBCLC
Texas Tech University School of Medicine
Email: kkendallt@gmail.com

Secretary

Amber N. Douglas, Ph.D.
Mt. Holyoke College
Email: adouglas@mtholyoke.edu

Treasurer

Beth N. Rom-Rymer, Ph.D.
President, Rom-Rymer and Associates
Email: docbnrr@gmail.com

Members-at-Large

Christine Dunning, Ph.D.
University of Wisconsin, Milwaukee
Email: cdunning@uwm.edu

Dawn M. Hughes, Ph.D.

Email: hughes@drdawnhughes.com

Sylvia A. Marotta, Ph.D., ABPP

The George Washington University
Email: syl@gwu.edu

Council Representatives APA

Joan M. Cook, Ph.D.
Yale University School of Medicine
Email: Joan.Cook@yale.edu

Sandra Mattar, Psy.D.

Saint Mary's College
Email: sm26@stmarys-ca.edu

Early Career Psychologist Representative

Lesia M. Ruglass, Ph.D.
The City College of New York
Email: ruglass.ccnny@gmail.com

Journal Editor

Psychological Trauma: Theory, Research, Practice, and Policy
Steven N. Gold, Ph.D.
Nova Southeastern University
Email: gold@nova.edu

Professional Affiliate Representative

Irene Sullivan, J.D.
Email: irenesullivan36@tampabay.rr.com

Student Representative

Jessica Punzo, B.S., M.A.
Email: jpunzo@my.adler.edu

Standing Committees

Awards Committee

Elana Newman, Ph.D., Chair
University of Tulsa
Email: elana-newman@utulsa.edu

Committee on Collaborative Endeavors

Constance Dalenberg, Ph.D., Chair
Alliant International University
Email: cdalenberg2@alliant.edu

Disaster Relief Committee

Gilbert Reyes, Ph.D., Chair
Fielding Graduate University
Email: greyes@fielding.edu

Diversity and Multicultural Committee

Sylvia A. Marotta, Ph.D., ABPP, Chair
The George Washington University
Email: syl@gwu.edu

Early Career Psychologists Committee

Lesia M. Ruglass, Ph.D., Chair
The City College of New York
Email: ruglass.ccnny@gmail.com

Education and Training Committee

Elana Newman, Ph.D., Chair
University of Tulsa
Email: elana-newman@utulsa.edu

Fellows Committee

Laurie Anne Pearlman, Ph.D., Chair
Email: lpearlmanphd@comcast.net

Finance Committee

Beth N. Rom-Rymer, Ph.D., Chair
President, Rom-Rymer and Associates
Email: docbnrr@gmail.com

International Committee

Elizabeth Carl, Ph.D., Chair
Email: drccarl@optonline.net

Liaison Committee

Catherine C. Classen, Ph.D., C. Psych.,
Chair
Women's College Hospital
Email: catherine.classen@wchospital.ca

Membership Committee

Lisa Rocchio, Ph.D., Chair
Email: lorocchio@cox.net

Nominations and Election Committee

Terry Keane, Ph.D., Chair
VA Boston Healthcare System & Boston
University
Email: terry.keane@va.gov

Policy Committee

Diane Elmore, Ph.D., MPH., Chair
American Psychological Association
Email: delmore@apa.org

Practice Committee

Bethany Brand, Ph.D., Co-Chair
Towson University
Email: bbrand@towson.edu

Peter M. Barach, Ph.D., Co-Chair

Case School of Medicine
Email: peter.barach@gmail.com

Program Committee

Carlos Cuevas, Ph.D., Co-Chair
Northeastern University
Email: c.cuevas@neu.edu

Walker Karraa, Ph.D., Co-Chair

Email: walker@walkerarraa.com

Publications Committee

Christine Courtois, Ph.D., Chair
Christine A. Courtois, Ph.D., & Associates,
PLC
Email: cacourtoisphd@aol.com

Science Committee

Brian Marx, Ph.D., Chair
National Center for PTSD
Email: brian.marx@va.gov

Special Interest Groups

Stacey Seibel, Ph.D., Chair
Park Nicollet Clinic: Sexual Health
Email: stacey.seibel@parknicollet.com

Student Affairs Committee

Jessica Punzo, B.S., MA, Chair
Email: jpunzo@my.adler.edu

Newsletter Editor

TRAUMA PSYCHOLOGY NEWSLETTER
Simon A. Rego, Psy.D., ABPP, ACT
Montefiore Medical Center
Email: sreg@montefiore.org

Associate Editor

Renu Aldrich, MA, MFTI
Center for Coping
Email: renu@renualdrich.com

Web Editor

www.apatraumadivision.org
Tyson Bailey, Psy.D.
Email: tdbaileypsyd@gmail.com

Listserv Manager

M. Rose Barlow, Ph.D.
Boise State University
Email: rosebarlow@boisestate.edu

Task Forces

Diversity Issues Task Force

Priscilla Dass-Brailsford, Ed.D., CTS, Co-Chair
Georgetown University Hospital
Email: pd227@georgetown.edu

Sandra Mattar, Psy.D., Co-Chair

Saint Mary's College
Email: sm26@stmarys-ca.edu

Task Force on the Assessment of Trauma Sequelae

Judith Armstrong, Ph.D., Chair
Email: jarmstro@usc.edu

Ethical Issues in Forensic Cases Involving Trauma and Abuse Issues Task Force

Phillip J. Kinsler, Ph.D., Co-Chair
Dartmouth Medical School
Email: psyfil@earthlink.net

Beth N. Rom-Rymer, Ph.D., Co-Chair

President, Rom-Rymer and Associates
Email: docbnrr@gmail.com

Task Force on Trauma Psychology and Social Justice

Amber Douglas, Ph.D., Chair
Mt Holyoke College
Email: douglasambers@gmail.com

Division 56 Member Services

Join Division 56: www.apa.org/divapp

Renew Division 56: APA Members, Associates, and Fellows may renew via www.apa.org/membership/renew.aspx. Professional Affiliates (professionals with no membership in APA) and Student Affiliates may renew at www.apa.org/divapp.

Membership Term: Membership is for January-December. If you apply during August-December, your membership will be applied to the following January-December.

Website: www.apatraumadivision.org

Listservs: Everyone is added to the announce listserv, div56announce@lists.apa.org (where news and announcements are sent out; membership in Division

56 is required). To join the discussion listserv, div56@lists.apa.org (where discussion happens; membership is not required), send a note to listserv@lists.apa.org and type the following in the body of the note: subscribe div56

Journal: You can access the journal, *Psychological Trauma: Theory, Research, Practice, and Policy*, online at www.apa.org via your myAPA profile. Log in with your user ID or email and password.

Newsletter: The newsletter is sent out on the announce listserv and is available on the website.

Membership Issues: Email division@apa.org or phone 202-336-6013.

Presidential Voice

continued from p. 1

Those of you who have interest in technology should email me about joining our Mental Health Application Database committee as an evaluator. APA has declared its commitment to increasing integration with technology at every level, and Division 56 joined with 29 (Psychotherapy) and 46 (Media Psychology and Technology) to put in a CODAPAR grant to fund a new initiative. We plan to start a database of mental health apps on stress/anxiety/trauma, to be expanded to other areas by other divisions in later years. Both divisions have committed to helping us develop this database with or without APA's help, but we are hopeful. We plan to present three expert reviews of each app that passes the initial screening of the committee with the hopes of eventually being the go-to place for finding mental health apps to aid the trauma professional. Use of new media was well represented in the 2013 convention, from Terry Keane's presentation of improving PTSD assessment and treatment in OEF-OIF veterans using new media, to Michael De Arellano's discussion of trauma focused CBT with children via telemedicine, and Joe Ruzek's description of the newest work on the most comprehensive trauma-focused app to date (PTSD Coach). I particularly appreciated the hours of work that Simon Rego must have put in to present his comprehensive sweep of available apps in many categories. He has graciously agreed to make his talk accessible to those who wished to see the list, so email me if you missed the talk or if you asked for a copy and did not yet receive it (cdalenberg@san.rr.com).

The convention had a third wave focus on distress tolerance and affect regulation. John Briere's talk on empirical bases of mindfulness; George Bonanno's discussion of trauma, resilience and regulatory flexibility; and Jill Stoddard's work on Acceptance and Commitment Therapy (presented by Grace Verbeck) were most centrally related to this theme. I urge you to consider adding John Briere's update of his *Principles of Trauma Therapy* to your library. I recommend it to virtually every student I teach. Similarly, Jill Stoddard's book on new ACT metaphors will soon hit the press. George Bonanno has a great book on grief (*The Other Side of Sadness*) that may interest you, but I would especially recommend his recent work on changes in trauma memory over time and on positive adjustments to adversity (search those terms to find the articles).

We should take a moment here to thank three people who did the most work to make this convention a reality—Denise Sloan and Carlos Cuevas, the program chairs, and Jan Estrellado, suite coordinator. Denise and Carlos were responsible for everything from helping me to choose the program participants to arranging

every detail of the program presentation—food, suite choice, media options, etc. Jan Estrellado stepped in at the last minute to arrange our suite presentations—the biofeedback training session with Don Moss, the research mentoring opportunities (Terry Keane, Joan Cook, Diane Castillo, Sylvia Marotta, Steve Gold, Constance Dalenberg and Kathy Kendall-Tackett participated this year), and the forensic workshop (with Laura Brown, Steve Gold and Lisa Rocchio). If you are planning to come to the APA convention in August 2014, remember that this service (free professional mentorship regarding placement of your article, statistical consulting on your work, or general research or clinical mentorship) is free to Division 56 members. This year we had very specialized workshops for trauma-focused professionals, teaching them to use biofeedback devices and providing an introduction to forensic work with trauma (with a CD of important resources). Don't forget to look into the suite programming available next year—it is a special service for Division 56 members.

Our awards ceremony was a big hit. The silent auction featured over 50 nationally recognized artists who donated work to Division 56 for auction. In the same tightly packed hour, we honored the following individuals (for more detailed biographies of the winners, see page 35):

- *Lifetime Achievement in the Field of Trauma Psychology*: Patricia A. Resick, PhD, the developer of Cognitive Processing Therapy, an effective short-term therapy for PTSD and corollary symptoms.
- *Outstanding Contributions to the Science of Trauma Psychology*: Dan King, PhD, and Lynda King, PhD, in recognition of their incomparable contributions to the development of statistical methods in trauma psychology and their years of service as statistical editors for *Psychological Trauma*.
- *Outstanding Contributions to Practice in Trauma Psychology*: Allan N. Schore, PhD, for his critical role in the development of modern understandings of neuroscience and developmental attachment theory as they relate to trauma.
- *Outstanding Service to the Field of Trauma Psychology*: Terence M. Keane, PhD, honoring his outstanding research productivity and mentorship, his years of leadership in the field of trauma, and particularly for his role as one of the intellectual and practical founders of Division 56.
- *Outstanding Early Career Achievement in Trauma Psychology*: Paul Frewen, PhD, co-

author of *Healing the Traumatized Self: Consciousness, Neuroscience & Treatment* as well as many articles on mindfulness, dissociation, and functional neuroimaging.

- *Outstanding Early Career Award for Ethnic Minority Psychologists in Trauma Psychology*: Christine L. Chee, PhD, recognizing Dr. Chee's research and clinical work, with emphasis on her study of cultural bias as a factor in the recounting of trauma.
- *Outstanding Dissertation in the Field of Trauma Psychology*: Courtney Welton-Mitchell, PhD. Her dissertation investigated memory, emotional processing, and attitudes related to domestic violence public service ads using multiple methods and samples.
- *Outstanding Media Contribution to the Field of Trauma Psychology* (two winners):
 - Jessica L. Hamblen, PhD, for AboutFace, a public awareness campaign designed to help veterans recognize their PTSD and motivate them to seek evidence based treatment
 - Alex Kotlowitz for This American Life (Harpers High School and In Country, In City), and the *New York Times* editorial on community violence

In addition, as President, I was happy to present a special award of recognition to Frank Putnam, MD, for his contribution to the science and practice of trauma psychology. Frank's contributions crossed almost all of our categories, and could not be confined to one award. In his acceptance speech, Frank said that he was particularly honored to receive this award from the "big" APA. We too were deeply honored by his acceptance.

We should also mention that this was the first year of our poster awards, under the able direction of Brian Marx with the aid of Elana Newman as an additional judge. We awarded a best poster and 2 honorable mentions and 15 outstanding poster awards (out of our approximately 100 entries). Outstanding poster awards were awarded to those who received mean ratings at or above 3 on our 4-point scale. Winners of the awards were Telsie Davis for the poster "Post-traumatic stress disorder, alcohol use, and life stress among African American women" (honorable mention), Yusuchi Kyutoku for the poster "Predicting victim vulnerability using PTSD trajectory patterns following the Tohoku earthquake" (honorable mention) and Lauren Ng for "Linguistic components of

genocide testimonies predict trauma symptoms" (Best poster). Consider applying next year to be part of this competitive event to improve your resume while being part of a phenomenal group of trauma specialists.

So many other events were part of the 2013 convention (I should mention Phil Zimbardo's time perspective contribution to PTSD treatment here), but the most inspiring is the opportunity to be with people who have a central commitment to providing a foundation for trauma training. Exemplars of that tradition are:

- *Joan Cook and Elana Newman*, who presented their findings from the New Haven conference (Advancing the Science of Education, Training and Practice in Trauma) on the consensus among professionals on the foundations of trauma training
- *Judith Armstrong*, our fearless leader on the Trauma Assessment guidelines, now in the hands of APA for their approval
- *Chris Courtois*, former President, chair of our task force on development of guidelines on complex trauma, now chair of the first APA treatment guidelines task force (on PTSD)
- *Terry Keane*, Immediate Past President and this year's winner of the Service award, who is among the individuals who qualifies under virtually every award category, and who has mentored so many of our trusted colleagues
- *Laura Brown*, mentor for so many of us in both clinical and leadership roles, who played such a crucial role in development of our bylaws and procedures
- *Steve Gold*, former President, and the guy who brought our journal into its young adulthood as a major psychological journal.

We continue to be an innovative and active division, drawing in trauma scientists of the high caliber that you can see in the lists within this document. One new document is "Trauma Research and the Institutional Review Board" (see page 43), which you can access on our website to help you with questions that your local IRB might raise about trauma research. This document, which was born from a series of questions raised by our student members (led this year by Jessica Punzo), is an example of the type of service that Division 56 can provide, in which you too can become a participant. The application period is coming up. Spread the word and notify us about your own areas of interest!!

Retrospective View on the History of Diagnosis of PTSD and Our Evolving Understanding of How Best to Treat Individuals

Edna B. Foa, PhD
 Center for the Treatment and Study of Anxiety
 University of Pennsylvania

Carmen P. McLean, PhD
 Center for the Treatment and Study of Anxiety
 University of Pennsylvania

David A. Yusko, PsyD
 Center for the Treatment and Study of Anxiety
 University of Pennsylvania

This issue of *Trauma Psychology Newsletter* provides a retrospective view on the history of the diagnosis of Post-Traumatic Stress Disorder (PTSD) and on our evolving understanding of how best to treat individuals suffering from this often chronic and debilitating disorder. The effects of trauma were described by authors, anthropologists, and scientists long before PTSD was introduced into the *Diagnostic and Statistical Manual of Mental Disorders* as one of the anxiety disorders. Trauma induced psychopathology has been given many labels over the centuries, including combat fatigue, war neurosis, soldier’s heart, and post-Vietnam syndrome. But it wasn’t until 1980 that the American Psychiatric Association (APA) added PTSD to the third edition of its *Diagnostic and Statistical Manual of Mental Disorders* (APA, 1980).

Once PTSD received formal recognition as a mental health diagnosis, it promoted the interest of the psychological community to study its nosology, prevention, and treatment. We now know that lifetime

prevalence of PTSD in the US is 7% (Kessler et al., 2005) and the prevalence of PTSD varies across traumatized populations. For example, prevalence of PTSD among veterans of Operation Iraqi Freedom has been estimated to be as high as 19.9% (Hoge et al., 2004) and women who have been sexually assaulted have a lifetime prevalence of PTSD as high as 50% (Creamer, Burgess, & McFarlane, 2001). Not only is PTSD quite prevalent, but it has the highest rate of psychiatric comorbidity of any disorder other than depression (Brown et al., 2001) and it is strongly associated with comorbid physical health problems as well (Sareen, Cox, Clara, & Asmundson, 2005). In addition to information about the psychopathology of PTSD, since PTSD gained the status of a disorder about three decades ago, much has been learned about how to effectively treat PTSD and help sufferers recover from this debilitating disorder.

The article by Dr. Richard McNally summarizes the emergence of PTSD’s recognition in the 1970s during the aftermath of the Vietnam War. He discusses the evolving nature of the diagnosis through each iteration of the DSM and then walks us through the development of effective treatments for PTSD. He outlines how early conceptualizations of anxiety and fear led to the development of the first treatment protocols and brings us up to date with the most recent theoretical accounts for the disorder and the treatments that stem from them.

The next two articles, by Dr. Patricia Resick and Drs. Norah Feeny and Nina Rytwinski, describe the history of two great success stories in developing

Special Section: History and Development of Trauma Treatments

Guest Editors: Edna B. Foa, PhD; Carmen P. McLean, PhD; and David A. Yusko, PsyD

Retrospective View on the History of Diagnosis of PTSD and Our Evolving Understanding of How Best to Treat Individuals.....	5
<i>Edna B. Foa, PhD, Carmen P. McLean, PhD, and David A. Yusko, PsyD</i>	
The Evolving Conceptualization and Treatment of PTSD: A Very Brief History.....	7
<i>Richard J. McNally, PhD</i>	
Cognitive Processing Therapy	11
<i>Patricia A. Resick, PhD, ABPP</i>	
A Brief (Not Prolonged) History of Prolonged Exposure Therapy for PTSD	14
<i>Norah C. Feeny, PhD, and Nina Rytwinski, PhD</i>	
Dissemination of EBTs for PTSD: Past and Future.....	17
<i>Josef I. Ruzek, PhD</i>	

empirically supported treatments for PTSD—cognitive processing therapy (CPT) and prolonged exposure (PE), respectively. First, Dr. Resick shares her unique perspective on how CPT emerged over the years given her leading role in its development. She describes her first experiences with trauma before the diagnosis of PTSD, early research studies with trauma, and how these efforts ultimately led to the first CPT study in 1988. Dr. Resick provides a concise review of the literature supporting CPT and describes recent research that has helped refine CPT to what it is today.

Dr. Feeny began her career working with Dr. Edna Foa, the developer of PE, at a time when Dr. Foa was conducting the first treatment studies using PE with women sexual assault survivors. In the article on the history of PE, Dr. Feeny and Dr. Rytwinski provide unique insights into how the theory of emotional processing informed the development of PE. Exposure therapy predates PE, so Drs. Feeny and Rytwinski describe how PE grew out of the larger context of exposure treatments, how and why PE uses in vivo and imaginal exposure techniques, and the mechanisms underlying the efficacy of PE. This article also touches on a challenge that PE and other empirically supported treatments face, which is how we can get this treatment out of the “lab” and into the community so the public has greater access to effective care.

This brings us to the last article by Dr. Josef Ruzek which focuses on disseminating treatments for PTSD. Dr. Ruzek is the director of dissemination and training for PTSD within the Department of Veterans Affairs. He has been closely involved with the rollout of PE throughout the entire VA Healthcare system. His involvement in this enormous dissemination effort gives Dr. Ruzek an exceptional perspective on the successes and difficulties of introducing evidence based treatments into large and small health care systems. Dr. Ruzek presents a variety of possible solutions for increasing access to evidence-based treatments, including clinical practice guidelines and training



Edna B. Foa, PhD



Carmen P. McLean, PhD



David A. Yusko, PsyD

initiatives, and concludes with a call for research on how to disseminate, implement, and sustain changes in PTSD treatment. In the end, the availability of effective treatments is of little value if the patients who stand to benefit from them most do not receive them.

In this special series, we have focused on two evidence-based treatments for PTSD: PE and CPT. It is important to note that there are a number of additional treatments that have empirical support for treating PTSD, including cognitive therapy, eye-movement desensitization and reprocessing (EMDR), stress inoculation training, as well as specific medications like paroxetine and sertraline. There is also exciting ongoing research examining ways of increasing the efficacy and efficiency of PTSD treatments, especially prolonged exposure, as well as research examining the efficacy of prolonged exposure for PTSD patients with comorbidities such as substance use, borderline personality disorder, and severe mental illness. Lastly, research into treatment enhancers like virtual reality, and medications such as D-cycloserine and methylene blue, hold promise for developing more efficient and effective treatments for PTSD.

Anyone working in the field of trauma is acutely aware of the potentially devastating impact trauma can have on the lives of those it touches. While we know many people are resilient and naturally recover from trauma without treatment, a significant minority do not. We would like to repeat a message that we believe cannot be said enough times: Those suffering from trauma are not alone, they do not need to suffer in silence or loneliness, and effective treatment is available. One problem is the lack of methods to routinely detect PTSD in community clinics; the vast majority of PTSD sufferers do not identify their disorder and thus do not present it to their clinicians. If you are wondering what you can do to help, we suggest a simple intervention of screening every patient who comes to your clinic or practice by using a trauma questionnaire. The National Center

for PTSD is a tremendous resource and free screening materials are readily available on their website (<http://www.ptsd.va.gov/professional/pages/assessments/ptsd-checklist.asp>). So much work has gone into understanding what PTSD is and how to effectively treat it; we now need to increase the awareness of the public and mental health professionals regarding what we have learned.

References

- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- Brown, T.A., Campbell, L.A., Lehman, C.L., Grisham, J.R., & Mancill, R.B. (2001). Current and lifetime comorbidity of the DSM-IV anxiety and mood disorders in a large clinical sample. *Journal of Abnormal Psychology, 110*(4), 585-599.
- Creamer, M., Burgess, P., & McFarlane, A.C. (2001). Post-traumatic stress disorder: Findings from the Australian National Survey of Mental Health and Well-being. *Psychological Medicine, 31*(7), 1237-1247.
- Hoge, C.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I., & Koffman, R.L. (2004). Combat duty in Iraq and Afghanistan: Mental health problems and barriers to care. *New England Journal of Medicine, 351*, 13-22.
- Kessler, R.C., Chiu, W.T., Demler, O., & Walters, E.E. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry, 62*(6), 617-627.
- Sareen, J., Cox, B. J., Clara, I., & Asmundson, G. J. (2005). The relationship between anxiety disorders and physical disorders in the US National Comorbidity Survey. *Depression and Anxiety, 21*(4), 193-202.

Edna B. Foa, PhD, is a Professor of Clinical Psychology in Psychiatry at the University of Pennsylvania and Director of the Center for the Treatment and Study of Anxiety. She received her PhD in Clinical Psychology and Personality, from University of Missouri, Columbia, in 1970. Dr. Foa devoted her academic career to studying the psychopathology and treatment of anxiety disorders, primarily obsessive-compulsive disorder (OCD), Post-Traumatic Stress Disorder (PTSD), and social phobia and is currently one of the world's leading experts in these areas.

Carmen P. McLean, PhD, is an Assistant Professor of Clinical Psychology in Psychiatry at the Center for the Treatment and Study of Anxiety. Dr. McLean received her Bachelor's degree in psychology from the University of British Columbia and her Master's and Doctoral degrees in clinical psychology from the University of Nebraska at Lincoln. After completing her clinical internship at the University of Chicago Medical Center in 2008, Dr. McLean completed a postdoctoral fellowship at the National Center for PTSD at the Boston VA, where she conducted research on Web-based interventions for PTSD. Her current interests include gender effects in anxiety disorders, treatment augmentation, and novel treatment delivery methods. Dr. McLean specializes in Prolonged Exposure Therapy (PE) for PTSD, Exposure and Response Prevention (EX/RP) for OCD, and cognitive-behavioral treatment for social anxiety, panic disorder, specific phobias, and generalized anxiety.

David A. Yusko, PsyD, is the Clinical Director at the Center for the Treatment and Study of Anxiety in the Perelman School of Medicine at the University of Pennsylvania. He joined the faculty in 2006 after completing his doctoral internship at Montefiore Hospital in New York City. He received his PsyD in clinical psychology from the Graduate School of Applied and Professional Psychology at Rutgers University where his training specialized in cognitive behavioral treatments for addictive behaviors. Since joining the CTSA faculty, Dr. Yusko has extended his interest in addictions to the development of effective treatments for co-occurring posttraumatic stress disorder (PTSD) and substance use. Dr. Yusko specializes in Prolonged Exposure Therapy (PE) for PTSD, Exposure and Response Prevention (EX/RP) for OCD, and cognitive-behavioral treatment for social anxiety, panic disorder, specific phobias, and generalized anxiety.

The Evolving Conceptualization and Treatment of PTSD: A Very Brief History

Richard J. McNally, PhD
Harvard University

American psychiatry ratified posttraumatic stress disorder (PTSD) as a distinct syndrome over 30 years ago when it published the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*; American Psychiatric Association [APA], 1980). Breaking with tradition, the *DSM-III* furnished explicit diagnostic criteria for its syndromes in an effort

to increase the reliability of psychiatric diagnoses. One happy consequence of this change was that it greatly stimulated research on the epidemiology, psychopathology, and treatment of mental disorders, including PTSD.

In this article, I briefly sketch the history of PTSD, and the development of psychological treatments for it. My purpose is to review key points in the history of both, and to underscore exciting new developments.

Historical Sketch of the PTSD Diagnosis

The PTSD diagnosis emerged during the late 1970s in the tumultuous aftermath of the Vietnam War (McNally, 2003). Although the rate of psychiatric casualties among American troops was much lower during this war than in previous wars, many Vietnam veterans began experiencing substantial psychological problems long after their return to civilian life. Yet no single diagnosis in the current diagnostic manual captured their problems adequately, and the emergence of their difficulties long after their separation from the service was historically anomalous. Psychiatric problems, such as “shell shock” in World War I and “battle fatigue” in World War II, erupted during war, not years later. Accordingly, anti-war psychiatrists and other advocates for veterans argued that the Vietnam War produced a new kind of stress syndrome, one that often emerged years after the trauma and could have a chronic course. They called it the Post-Vietnam Syndrome, and lobbied for its inclusion in the then-forthcoming *DSM-III*.

Advocates for the new diagnosis encountered obstacles. Skeptics questioned the wisdom of recognizing a medical syndrome tied to a specific historical event, and they wondered whether it was largely a social product of a politically controversial war. Moreover, one aim of the new manual was to characterize syndromes descriptively without reference to speculative etiological theories. Yet Post-Vietnam Syndrome came with its own etiology: exposure to the trauma of a specific war.

Several events enabled the advocates to succeed. They made common cause with clinical researchers who were reporting broadly similar posttraumatic symptoms in survivors of disasters, rape, and the Holocaust. Rather than viewing the troubles of veterans as unique to the Vietnam War, advocates reversed their position, interpreting them as indicative of a universal psychobiological response to any overwhelming trauma. An influential member of the *DSM-III* committee agreed, noting how she had observed similar psychiatric symptoms in her patients who had suffered massive burns. Decoupled from its historical context, the Post-Vietnam Syndrome became PTSD in the new manual.

Although the diagnosis has evolved during the subsequent three iterations of the *DSM*, several core features have persisted. Requisite for the diagnosis is exposure to a traumatic event and involuntary recollection of the event, exemplified by the reexperiencing symptoms of intrusive images,

flashbacks, and nightmares, underscoring how central memory is to the disorder (McNally, 2003, pp. 105-158). Avoidance of reminders of the trauma, emotional numbing (e.g., difficulty experiencing positive emotions), and heightened arousal (e.g., startle, irritability, hypervigilance) are further diagnostic hallmarks.

Implicit in the formulation of the diagnosis was the assumption that the syndrome arose in response to unquestionably horrific, life-threatening trauma, not to the ordinary stressors of everyday life. Another assumption was that trauma, not other factors, bore the causal burden of producing the symptomatic profile of PTSD. Two sets of empirical findings subverted these assumptions.



Richard J. McNally, PhD

Studies began to emerge showing that people exposed to noncanonical stressors failing to qualify for the *DSM* definition of *trauma* nevertheless met symptomatic criteria for the disorder (Dohrenwend, 2010). Subverting the other assumption were epidemiological studies showing that undeniably traumatic stressors were insufficient to produce the disorder in the majority of victims (e.g., Breslau, Davis, Andreski, & Peterson, 1991). Hence, the field encountered a puzzle. Many people developed the syndrome after encountering presumably subtraumatic

stressors, whereas others failed to develop it despite encountering severe stressors. Taken together, these findings implied that our original concept of PTSD and its causation was far too simplified. Memory for trauma alone could not carry the causal burden of producing PTSD; risk and resilience variables would have to figure prominently in the etiological equation. A major theoretical aim today is to elucidate how these variables, once ignored, interact with memory for trauma to produce the signs and symptoms of PTSD.

Scholars in the flourishing field of traumatic stress studies considered whether PTSD was a timeless, ahistorical response to trauma or a culture-bound idiom of distress arising chiefly in societies influenced by late 20th century American culture (Young, 1995). This research uncovered an apparent paradox. Researchers detected PTSD around the globe, affirming its cross-cultural occurrence (Osterman & de Jong, 2007). Yet military historians, studying medical archival data, found that psychiatric syndromes occurring in combat veterans have varied throughout the 20th century, even within Anglo-American culture (Jones et al., 2002). The differences between shell shock and PTSD were at least as great as their similarities, implying that historical niches can shape the phenomenology of trauma-induced syndromes.

However, debates about whether shell shock, battle fatigue, soldier's heart, nostalgia, and so forth were merely surface variations reflective of a timeless, underlying latent entity (or dimension) presupposed an essentialist construal of mental disorder. According to this view, symptoms are fallible indicators of the unobserved disease process. Yet other views are emerging (McNally, 2011, pp. 203-211). A realist, but nonessentialist, perspective is the causal systems view that conceptualizes disorders as networks of causally interacting symptoms that settle into pathological equilibria (e.g., Borsboom et al., 2011). Symptoms do not *reflect* an underlying latent entity or dimension; they are *constitutive* of disorder. The causal systems approach can deepen our understanding of PTSD and dissolve controversies regarding its cultural versus biological roots (McNally, 2012a).

Historical Sketch of PTSD Treatments

Inadequate etiological models of mental disorder may inspire effective treatments, as the history of anxiety disorders so vividly exemplifies. For example, behavior therapists pioneered genuinely effective treatments for phobias by conceptualizing them as arising from Pavlovian fear conditioning (Wolpe, 1958), and sustained by instrumental avoidance responses that prevented such neurotic fears from extinguishing. Ironically, the theoretical foundation of this two-factor theory of conditioned fear and instrumental avoidance had already been undermined by the cognitive revolution in psychology when behavior therapists deployed it so successfully to help people overcome phobias, and the cognitive revolution had long been underway when behavior therapists extended the model to PTSD (Keane, Zimering, & Caddell, 1985). According to this model, trauma establishes initially neutral cues as conditioned stimuli (CSs) for the conditioned response (CR) of fear, and avoidance of these CSs prevents the extinction of CRs. Therefore, exposing PTSD patients to reminders of their trauma until their distress subsides should facilitate their recovery. Exposure could involve activation of memories of the trauma as well as *in vivo* exposure to reminders in everyday life. Despite the theoretical limitations of the two-factor model, the exposure principle remains the bedrock of evidenced-based treatments for PTSD (Institute of Medicine, 2007). Multiple randomized trials document the efficacy of prolonged exposure (PE) for PTSD (e.g., Foa et al., 1999; Foa et al., 2005; Taylor et al., 2003). Exposure therapy delivered via virtual reality shows promise as the latest embodiment of this therapeutic principle (Reger et al., 2011).

Limitations of the original behavioral model of PTSD motivated models emphasizing emotional (Foa, Steketee, & Rothbaum, 1989) and cognitive processing (Ehlers & Clark, 2000) that, in turn, inspired research on the mediators of change during exposure (Foa & Rauch, 2004) and cognitive (Kleim et al., 2013)

for PTSD. Although these theoretical developments partly reflected changes in how clinicians understood traditional exposure therapies for anxiety disorders in general (Foa & Kozak, 1986), they also shaped efficacious new treatments that included exposure, but emphasized cognitive therapy (Ehlers et al., 2003; Resick et al., 2008; Resick, Nishith, Weaver, Astin, & Feuer, 2002). Some studies have failed to find any incremental benefit from adding cognitive restructuring to exposure therapy (Foa et al., 2005), whereas subsequent studies have found additive benefit (Bryant et al., 2003), including one that showed that a combination of exposure therapy plus cognitive restructuring was more efficacious than either one alone (Bryant et al., 2008a). Finally, women whose PTSD arose from childhood sexual abuse benefited more from exposure therapy after first undergoing training in skills designed to improve emotion regulation and interpersonal relations than those women who underwent exposure therapy alone (Cloitre et al., 2010).

Shapiro's (1995) Eye Movement Desensitization and Reprocessing (EMDR) provoked lively debate when it first appeared on the scene in the late 1980s. Hailed as a potentially revolutionary treatment for PTSD and many other ailments, EMDR promised rapid reduction of distress associated with traumatic memories. Therapists prompted patients to access traumatic memories while tracking the therapist's finger as she waved it back and forth in front of the patient's eyes. EMDR therapists conjectured that bilateral eye movements hastened the processing of traumatic memories. Skeptics questioned whether the defining ingredient, bilateral eye movement, possessed any therapeutic efficacy beyond the imaginal exposure component of EMDR. In some randomized controlled trials (RCTs) EMDR was just as efficacious as standard exposure therapy for PTSD (Rothbaum, Astin, & Marsteller, 2005), whereas in others it was efficacious, but less so than standard exposure therapy (Taylor et al., 2003). One meta-analysis suggested that EMDR with the eye movements was no more efficacious than EMDR without the eye movements (Davidson & Parker, 2001), thereby implying that "*what is effective in EMDR is not new, and what is new is not effective*" (McNally, 1999, p. 619).

Yet recent basic laboratory research (Gunter & Bodner, 2008), including with PTSD patients (van den Hout et al., 2012), indicates that secondary tasks, such as eye movements, that tax working memory during recollection of stressful memories attenuate their vividness and emotionality during subsequent recollection (van den Hout & Engelhard, 2012). Secondary tasks that do not tax working memory (e.g., passive listening to bilateral beeps) do not have this effect. In fact, the authors of a recent meta-analysis concluded, "the eye movements do have an additional value in EMDR treatments" (Lee & Cuijpers, 2013, p. 239).

Emerging Developments

The emotional, social, and economic costs of untreated PTSD have stimulated efforts to prevent the disorder, especially in those recently exposed to trauma. Although psychological debriefing methods, delivered to people shortly after exposure to trauma, do not prevent the emergence of PTSD and sometimes impede natural recovery from trauma (McNally, Bryant, & Ehlers, 2003), multiple sessions of exposure therapy administered to people suffering from acute stress disorder, does prevent the emergence of PTSD in many recent trauma victims (Bryant et al., 2008a).

The United States Army launched a Comprehensive Soldier Fitness program designed to build resilience skills to reduce the incidence of PTSD and other mental health problems prior to personnel deploying to combat zones (Cornum, Matthews, & Seligman, 2011). Unfortunately, the program never underwent rigorous pilot testing prior to implementation to confirm its efficacy and refine it if necessary (McNally, 2012b). However, the Army has conducted research showing that its Battlemind program does attenuate PTSD symptoms in returning soldiers with extensive combat exposure (Adler, Bliese, McGurk, Hoge, & Castro, 2009). Finally, guided by Edna B. Foa and Patricia A. Resick, the Department of Veterans Affairs (VA) has established an innovative program to disseminate evidence-based PE and CPT throughout VA hospitals to ensure that our recent wave of veterans get the best possible care for PTSD (Foa, Gillihan, & Bryant, 2013).

References

- Adler, A. B., Bliese, P. D., McGurk, D., Hoge, C. W., & Castro, C. A. (2009). Battlemind debriefing and Battlemind Training as early interventions with soldiers returning from Iraq: Randomization by platoon. *Journal of Consulting and Clinical Psychology, 77*, 928-940.
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- Borsboom, D., Cramer, A. O. J., Schmittmann, V. D., Epskamp, S., & Waldorp, L. J. (2011). The small world of psychopathology. *PLoS ONE, 6*(11), e27407, 1-11.
- Breslau, N., Davis, G. C., Andreski, P., & Peterson, E. (1991). Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry, 48*, 216-222.
- Bryant, R. A., Mastrodomenico, J., Felmingham, K. L., Hopwood, S., Kenny, L., Kandris, E., Cahill, C., & Creamer, M. (2008a). Treatment of acute stress disorder: A randomized controlled trial. *Archives of General Psychiatry, 65*, 659-667.
- Bryant, R. A., Moulds, M. L., Guthrie, R. M., Dang, S. T., Mastrodomenico, J., Nixon, R. D. V., Felmingham, K. L., Hopwood, S., & Creamer, M. (2008b). A randomized controlled trial of exposure therapy and cognitive restructuring for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 76*, 695-703.
- Bryant, R. A., Moulds, M. L., Guthrie, R. M., Dang, S. T., & Nixon, R. D. V. (2003). Imaginal exposure alone and imaginal exposure with cognitive restructuring in treatment of posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 71*, 706-712.
- Cloitre, M., Stovall-McClough, K. C., Noonan, K., Zorbas, P., Cherry, S., Jackson, C. L., Gan, W., & Petkova, E. (2010). Treatment for PTSD related to childhood abuse: A randomized controlled trial. *American Journal of Psychiatry, 167*, 915-924.
- Cornum, R., Matthews, M. D., & Seligman, M. E. P. (2011). Comprehensive Soldier Fitness: Building resilience in a challenging institutional context. *American Psychologist, 66*, 4-9.
- Davidson, P. R., & Parker, K. C. H. (2001). Eye movement desensitization and reprocessing (EMDR): A meta-analysis. *Journal of Consulting and Clinical Psychology, 69*, 305-316.
- Dohrenwend, B. F. (2010). Toward a typology of high-risk major stressful events and situations in posttraumatic stress disorder and related psychopathology. *Psychological Injury and Law, 3*, 89-99.
- Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38*, 319-345.
- Ehlers, A., Clark, D. M., Hackman, A., McManus, F., Fennell, M., Herbert, C., & Mayou, R. (2003). A randomized controlled trial of cognitive therapy, self-help booklet, and repeated early assessment as early interventions for PTSD. *Archives of General Psychiatry, 60*, 1024-1032.
- Foa, E. B., Dancu, C. V., Hembree, E. A., Jaycox, L. H., Meadows, E. A., & Street, G. P. (1999). A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology, 67*, 194-200.
- Foa, E. B., Gillihan, S. J., & Bryant, R. A. (2013). Challenges and successes in dissemination of evidence-based treatments for posttraumatic stress disorder: Lessons learned from prolonged exposure therapy for PTSD. *Psychological Science in the Public Interest, 14*, 65-111.
- Foa, E. B., Hembree, E. A., Cahill, S. P., Rauch, S. A. M., Riggs, D. S., Feeny, N. C., & Yadin, E. (2005). Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: Outcome at academic and community clinics. *Journal of Consulting and Clinical Psychology, 73*, 953-964.
- Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*, 20-35.
- Foa, E. B., & Rauch, S. A. M. (2004). Cognitive changes during prolonged exposure versus prolonged exposure plus cognitive restructuring in female assault survivors with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 72*, 879-884.
- Foa, E. B., Steketee, G., & Rothbaum, B. O. (1989). Behavioral/cognitive conceptualizations of post-traumatic stress disorder. *Behavior Therapy, 20*, 155-176.
- Gunter, R. W., & Bodner, G. E. (2008). How eye movements affect unpleasant memories: Support for a working-memory account. *Behaviour Research and Therapy, 46*, 913-931.
- Institute of Medicine. (2007). *Treatment of posttraumatic stress disorder: An assessment of the evidence*. Washington, DC: The National Academies Press.
- Jones, E., Hodgins-Vermaas, R., McCartney, H., Everitt, B., Beech, C., Poynter, D., Palmer, I., Hyams, K., & Wessely, S. (2002). Post-combat syndromes from the Boer war to the Gulf war: A cluster analysis of their nature and attribution. *BMJ, 324*, 1-7.
- Keane, T. M., Zimering, R. T., & Caddell, J. M. (1985). A behavioral formulation of posttraumatic stress disorder in Vietnam veterans. *The Behavior Therapist, 8*, 9-12.
- Kleim, B., Grey, N., Wild, J., Nussbeck, F. W., Stott, R., Hackmann, A., Clark, D. M., & Ehlers, A. (2013). Cognitive change predicts symptom reduction with cognitive therapy for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 81*, 383-393.
- Lee, C. W., & Cuijpers, P. (2013). A meta-analysis of the contribution of eye movements in processing emotional memories. *Journal of Behavior Therapy and Experimental Psychiatry, 44*, 231-239.
- McNally, R. J. (1999). On eye movements and animal magnetism: A reply to Greenwald's defense of EMDR. *Journal of Anxiety Disorders, 13*, 617-620.
- McNally, R. J. (2003). *Remembering trauma*. Cambridge, MA: The Belknap Press of Harvard University Press.
- McNally, R. J. (2011). *What is mental illness?* Cambridge, MA: The Belknap Press of Harvard University Press.
- McNally, R. J. (2012a). The ontology of posttraumatic stress disorder:

- Natural kind, social construction, or causal system? *Clinical Psychology: Science and Practice*, 19, 220-228.
- McNally, R. J. (2012b). Are we winning the war against posttraumatic stress disorder? *Science*, 336, 874-876.
- McNally, R. J., Bryant, R. A., & Ehlers, A. (2003). Does early psychological intervention promote recovery from posttraumatic stress? *Psychological Science in the Public Interest*, 4, 45-79.
- Osterman, J. E., & de Jong, J. T. V. M. (2007). Cultural issues and trauma. In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *Handbook of PTSD: Science and practice*, 425-446. New York: Guilford.
- Reger, G. M., Holloway, K. M., Candy, C., Rothbaum, B. O., Difede, J., Rizzo, A. A., & Gahm, G. A. (2011). Effectiveness of virtual reality exposure therapy for active duty soldiers in a military mental health clinic. *Journal of Traumatic Stress*, 24, 93-96.
- Resick, P. A., Galovski, T. E., Uhlmansiek, M. O., Scher, C. D., Clum, G. A., & Young-Xu, Y. (2008). A randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. *Journal of Consulting and Clinical Psychology*, 76, 243-258.
- Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002). A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology*, 70, 867-879.
- Rothbaum, B. O., Astin, M. C., & Marsteller, F. (2005). Prolonged exposure versus Eye Movement Desensitization and Reprocessing (EMDR) for PTSD rape victims. *Journal of Traumatic Stress*, 18, 607-616.
- Shapiro, F. (1995). *Eye Movement Desensitization and Reprocessing: Basic principles, protocols, and procedures*. New York: Guilford.

- Taylor, S., Thordarson, D. S., Maxfield, L., Fedoroff, I., Lovell, K., & Ogradniczuk, J. (2003). Comparative efficacy, speed, and adverse effects of three PTSD treatments: Exposure therapy, EMDR, and relaxation training. *Journal of Consulting and Clinical Psychology*, 71, 330-338.
- van den Hout, M. A., & Engelhard, I. M. (2012). How does EMDR work? *Journal of Experimental Psychopathology*, 3, 724-738.
- van den Hout, M. A., Rijkeboer, M. M., Engelhard, I. M., Klugkist, I., Hornsveld, H., Toffolo, M. J. B., & Cath, D. C. (2012). Tones inferior to eye movements in the EMDR treatment of PTSD. *Behaviour Research and Therapy*, 50, 275-279.
- Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.
- Young, A. (1995). *The harmony of illusions: Inventing post-traumatic stress disorder*. Princeton, NJ: Princeton University Press.

Richard J. McNally, PhD, is Professor and Director of Clinical Training in the Department of Psychology at Harvard University. He has more than 350 publications, most concerning anxiety disorders, and many on PTSD. A major focus of his trauma research has been the cognitive aspects of PTSD in war veterans and adult survivors of childhood sexual abuse. His books include *Remembering Trauma* (2003) and *What Is Mental Illness?* (2011). He was a member of the DSM-IV PTSD committee and a clinician-interviewer on the National Vietnam Veterans Readjustment Study.

Cognitive Processing Therapy

Patricia A. Resick, PhD, ABPP
National Center for PTSD, VA Boston Healthcare System and
Boston University

I started working in the field of trauma before there was such a diagnosis as PTSD. While on internship in Charleston, South Carolina, I was approached to be one of the first group of women to become rape crisis counselors at one of the first rape crisis centers. A few months after I started, NIMH put out an RFP for \$3,000,000 to fund research on rape. Dean Kilpatrick, Lois Veronen and I worked on a project to conduct a longitudinal study of fear and anxiety but also to conduct a clinical trial. Because we thought that the IRB of the time would be squeamish about doing a randomized controlled trial, we allowed the participants to choose which condition they wanted to receive. One of the therapies we adapted for rape victims was stress inoculation therapy (SIT), which focused on learning and practicing a range of coping skills so that the women would be less likely to avoid situations that were triggering their fear and anxiety. I worked on that study and another



Patricia A. Resick, PhD, ABPP

longitudinal study with Karen Calhoun in Atlanta for the next four years while commuting monthly from the University of South Dakota.

When I moved to the University of Missouri—St. Louis, I received a small internal grant to compare group SIT and assertion training (because it was presumably counter to the fear response and because so many of the women needed to assert themselves in social situations), to a control condition of general supportive counseling (Resick, Jordan, Girelli, Hutter, & Marhofer-Dvorak, 1988). All three groups improved equally but I wasn't satisfied with the extent of improvement or the fact that there were no differences. At the time, we didn't really understand how much sample size makes a difference with power to find differences between groups but it led me to look in different directions. Although women talked about fear, they also talked about believing that the rape was their fault, they must have let it happen, or that it must have been a misunderstanding. They talked about guilt, anger, shame, betrayal, distrust, the need to control all events, etc. It was not unusual for women to start the group by saying

that they weren't sure they belonged there because what happened to them probably was not a rape. Many of the women were depressed in addition to having what had just been labeled PTSD. I started reading the work of Aaron Beck and his colleagues on depression and anxiety and was drawn to the cognitive model and how changing cognitions would change emotions. It seemed like an appropriate approach for the women I was working with.

I started developing and testing cognitive processing therapy (CPT) in 1988 with individual clients and then started conducting it in groups. I had several priorities in developing CPT. One was that I wanted the clients to develop cognitive skills, not just have therapy "done to them." I wanted them to develop a new balanced way of thinking. Second, there were very few treatment manuals at the time and I wanted a systematic session by session treatment that builds skills and uses practice assignments that therapists could follow without a great deal of training. Though over the years, we have refined the Socratic dialogue component, and I do think that needs additional training and consultation. But at the time, I was thinking that rape crisis centers might use this for their groups and I wanted it to be as straightforward as possible. I conducted 84 pilot cases and conducted an open trial that was published in 1992 along with the treatment manual in 1993 (Resick & Schnicke, 1992, 1993) while trying to get funding to conduct a randomized controlled trial (RCT).

In 1994 I received a grant from NIMH to conduct an RCT to compare CPT against prolonged exposure (PE) and a waiting list control condition. Those who were assigned to the 6 week waiting list were also assigned by the data manager to one of the two treatment conditions should they decide to continue. Even if they didn't continue, we would know which active treatments the participants had been assigned to. That became very important when we decided to conduct a long term follow-up with the intention to treat (ITT) sample. Edna Foa provided the PE training twice, a year apart, and her lab conducted the adherence and competence ratings on the therapists. After 7 years of data collection, we had 171 in the ITT sample and 121 treatment completers in one of the three conditions. We found that for both PTSD and depression, the results between CPT and PE were nearly identical. The only difference was with guilt cognitions, with CPT improving guilt more than PE through the 9 month follow-up (Resick, Nishith, Weaver, Astin, & Feuer, 2002). Subsequently, we found that there were also differences in hopelessness (Gallagher & Resick, 2012) and self-reported health symptoms, but not in a range of "complex PTSD" symptoms (Resick, Nishith, & Griffin, 2003), or in borderline personality characteristics (Clarke, Rizvi, & Resick, 2008).

Toward the end of the study and while we were conducting a dismantling study that was a competing renewal of the grant, we decided to conduct a long-term

follow-up of the participants of the study. Because we had not originally planned to conduct a follow-up at least 5 years later, it took us quite a while to locate some of the original participants and eventually used the help of a survey research firm to help track their locations. We were able to conduct at least the interview (CAPS, SCID and follow-up interview) on 126 participants (70% of the original ITT sample and 85% of those we were able to positively locate). We found that both groups continued to have nearly identical results and that there was little relapse at any follow-up. At the long term follow-up which ended up being 4.5-10 years posttreatment, only 20% still had PTSD, the same percentage as at posttreatment and earlier follow-ups even after accounting for further therapy and medications (Resick, Williams, Suvak, Monson, & Gradus, 2012). Guilt cognitions continued to be better for CPT than PE patients (Resick, Williams, Orazem, & Gutner, 2005) and suicidal ideation had improved more for CPT than PE and was mediated by the CPT but not PE (Gradus, Suvak, Wisco, Marx, & Resick, 2013). Social and work functioning improved and there were no differences between treatments.

While conducting the long term follow-ups, we were also conducting a dismantling study to determine if both components of the treatment, cognitive therapy and written accounts of the trauma(s) were essential. We collected three groups, full CPT, CPT without the written accounts (CPT-C) and written accounts plus reading back to the therapist and non-cognitive processing (WA) produced similar results. Although the hypothesis was that both components were needed, CPT-C and CPT both had similar results and there was an overall group difference between CPT-C and WA. In looking at the point at which clinical change occurred, CPT-C evidenced clinically significant change by session 4, CPT by session 6 and WA by session 8 indicating that CPT-C might be more efficient. The scores for the CPT group did not start dropping until after the account writing was complete. By the 6 month follow-up there was no difference between the three conditions. Because of these findings, all of the studies that I have been conducting have been CPT-C rather than CPT (Resick et al., 2008).

Kathleen Chard conducted a combination of group and individual therapy for women with a history of child sexual abuse that was 17 weeks (Chard, 2005) and her results were better than the studies that I conducted. At post-treatment, only 7% of the treatment completers met criteria for PTSD and at the 1-year follow-up, 6% continued to have PTSD. In studying a variable length CPT, Tara Galovski and her colleagues (2012), who studied both men and women who had been victims of interpersonal violence and defined a treatment completer as someone who had met a good end-state on PTSD and depression, agreed that they had met their goals, and did not have a PTSD diagnosis on the CAPS by an independent assessor. They could stop as early

as the fourth session or could extend the therapy to 18 sessions. They also improved upon my original findings. On average, more than half of the sample completed treatment before 12 sessions (average 9) and a third continued past the 12 sessions. However, by the three month follow-up, only 1 of the 50 participants still had PTSD.

Because of these strong results with more sessions, we are now preparing to conduct a much larger variable length study with active duty soldiers at Ft. Hood, Texas. We plan to conduct therapy on 200 soldiers with PTSD and then to determine predictors of those who are early responders, normal responders, late responders (they will have up to 24 sessions) and non-responders. The studies with active military will be discussed below after discussing CPT studies with Veterans.

Candice Monson and colleagues (2006) were the first to conduct an RCT with CPT in VA. Their study started before the recent wars in Iraq and Afghanistan had produced Veterans, so most of the participants were Vietnam Veterans who had their PTSD for over 30 years. All of them had experienced substance dependence although none did at the time of treatment. Most had received years of therapy or medication from VA and the waiting list control group was allowed to continue with treatment as usual as long as they didn't receive a specific treatment for PTSD. However, given that evidence-based treatments were not being used in VA at the time, there was very little danger of that. They found that 40% of these Veterans lost their PTSD diagnosis over the course of the 12 session treatment. Forbes et al. (2012) followed this study with a study in an Australian VA that compared it to treatment as usual. They found very similar results. Leslie Morland (2011) has piloted and now completed a study comparing group CPT-C conducted through telehealth or in person. Conducting group CPT-C through telehealth is a particularly interesting challenge to take on.

Currently, through the STRONG STAR consortium, my colleagues and I have recently completed a study to see if group CPT could be effective with active military compared to present centered therapy (PCT). That study has been completed on 107 military members with six cohorts of each condition, and data analyses are currently underway. The next study, which is half-way through data collection, is a comparison of group versus individual CPT-C. This study will have public policy implication. A fourth study which will start soon through the STRONG STAR consortium in San Antonio is a comparison of CPT-C conducted in clinic as usual compared to in-home treatment or telehealth. This study has an equipoise design which means that participants can opt out of one of the three conditions if they choose to and will be randomized to one of the other treatments. Aside from determining whether CPT-C is equally effective in these domains, it will also be

interesting to determine whether the therapy domains are equally acceptable to participants.

With regard to cross-cultural work, CPT was examined for effectiveness with refugees. The intervention was conducted either through an interpreter or in the participant's language. Both were found to be effective (Schulz, Resick, Huber, & Griffin, 2006). Recently, Bass et al. (2013) published the results of a CPT-C RCT that was conducted in the Democratic Republic of Congo. Even though they had to simplify the worksheets and concepts because the participants were illiterate, had no paper and therefore had to memorize the worksheets, and the therapists had at best a junior high school education, they were very successful in remediating PTSD in a very dangerous and low resource environment. In a *New York Times* article about the study, Judy Bass said, "if you can do it (CPT-C) there, you can do it anywhere." There are currently several studies being conducted in Germany, including one with adolescents and one as a comparison condition for treatment of borderline personality.

Finally, there are a number of studies being conducted on CPT with PTSD and comorbid conditions, such as pain, alcohol abuse, smoking, and traumatic brain injury. The future results on the extent of CPT with varying populations and conditions will prove very interesting.

References

- Bass, J. K., Annan, J., McIvor Murray, S., Kaysen, D., Griffiths, S., Cetinoglu, T., . . . Bolton, P. A. (2013). Controlled trial of psychotherapy for Congolese survivors of sexual violence. *New England Journal of Medicine*, *368*(23), 2182-2191. doi: 10.1056/NEJ-Moa1211853
- Chard, K. M. (2005). An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse. *Journal of Consulting and Clinical Psychology*, *73*(5), 965-971. doi: 10.1037/0022-006X.73.5.965
- Clarke, S. B., Rizvi, S. L., & Resick, P. A. (2008). Borderline personality characteristics and treatment outcome in cognitive-behavioral treatments for PTSD in female rape victims. *Behavior Therapy*, *39*, 72-78. doi: 10.1016/j.beth.2007.05.002
- Forbes, D., Lloyd, D., Nixon, R. D., Elliott, P., Varker, T., Perry, D., . . . Creamer, M. (2012). A multisite randomized controlled effectiveness trial of cognitive processing therapy for military-related posttraumatic stress disorder. *Journal of Anxiety Disorders*, *26*(3), 442-452. doi: 10.1016/j.janxdis.2012.01.006
- Gallagher, M., & Resick, P. A. (2012). Mechanisms of change in cognitive processing therapy and prolonged exposure therapy for posttraumatic stress disorder: Preliminary evidence for the differential effects of hopelessness and habituation. *Cognitive Therapy and Research*, *36*(6), 750-755. doi: 10.1007/s10608-011-9423-6
- Galovski, T. E., Blain, L. M., Mott, J. M., Elwood, L., & Houle, T. (2012). Manualized Therapy for PTSD: Flexing the Structure of Cognitive Processing Therapy. *Journal of Consulting and Clinical Psychology*, *80*, 968-981. doi: 10.1037/a0030600
- Gradus, J. L., Suvak, M. K., Wisco, B. E., Marx, B. P., & Resick, P. A. (2013). Treatment of Posttraumatic Stress Disorder Reduces Suicidal Ideation. *Depression & Anxiety*. doi: 10.1002/da.22117
- Monson, C. M., Schnurr, P. P., Resick, P. A., Friedman, M. J., Young-Xu, Y., & Stevens, S. P. (2006). Cognitive processing therapy for veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *74*(5), 898-907. doi: 10.1037/0022-006X.74.5.898

- Morland, L. A., Hynes, A. K., Mackintosh, M., Resick, P. A., & Chard, K. M. (2011). Group Cognitive Processing Therapy delivered to veterans via telehealth: A pilot cohort. *Journal of Traumatic Stress, 24*(4), 465-469. doi: 10.1002/jts.20661
- Resick, P. A., Galovski, T. E., Uhlmansiek, M. O., Scher, C. D., Clum, G., & Young-Xu, Y. (2008). A randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. *Journal of Consulting & Clinical Psychology, 76*(2), 243-258. doi: 10.1037/0022-006X.76.2.243
- Resick, P. A., Jordan, C. G., Girelli, S. A., Hutter, C. K., & Marhofer-Dvorak, S. (1988). A comparative outcome study of behavioral group therapy for sexual assault victims. *Behavior Therapy, 19*, 385-401.
- Resick, P. A., Nishith, P., & Griffin, M. G. (2003). How well does cognitive-behavioral therapy treat symptoms of complex PTSD? An examination of child sexual abuse survivors within a clinical trial. *CNS Spectrums, 8*, 340-355.
- Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002). A comparison of cognitive processing therapy, prolonged exposure and a waiting condition for the treatment of posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology, 70*(4), 867-879. doi: 10.1037/0022-006X.70.4.867
- Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60*(5), 748-756.
- Resick, P. A., & Schnicke, M. K. (1993). *Cognitive processing therapy for rape victims: A treatment manual*. Newbury Park, CA: Sage Publications, Inc.
- Resick, P. A., Williams, L. F., Orazem, R., & Gutner, C. A. (2005). *Can we cure PTSD? Five year follow-up of a trial comparing CPT and PE*. Presented at the 21st meeting of the International Society for Traumatic Stress Studies, Toronto, ON.
- Resick, P. A., Williams, L. F., Suvak, M. K., Monson, C. M., & Gradus, J. L. (2012). Long-term outcomes of cognitive-behavioral treatments for Posttraumatic Stress Disorder among female rape survivors. *Journal of Consulting and Clinical Psychology, 80*(2), 201-210. doi: 10.1037/a0026602
- Schulz, P. M., Resick, P. A., Huber, L. C., & Griffin, M. G. (2006). The effectiveness of cognitive processing therapy for PTSD with refugees in a community setting. *Cognitive and Behavioral Practice, 13*, 322-331.

Patricia A. Resick, PhD, ABPP, is the Director of the Women's Health Sciences Division of the National Center for PTSD at the Veterans Affairs (VA) Boston Healthcare

System. She is a Professor of Psychiatry and Psychology at Boston University. Dr. Resick received her Doctorate in Psychology from the University of Georgia. During her career, she also served on the faculties of the University of South Dakota, the Medical University of South Carolina and the University of Missouri–St. Louis, where she held an endowed professorship. Dr. Resick has received grants from NIH, NIJ, CDC, SAMHSA, VA and DoD to provide services and conduct research on the effects of traumatic events, particularly on women, and to develop and test therapeutic interventions for PTSD. Specifically, she developed and tested Cognitive Processing Therapy, an effective short term treatment for PTSD and corollary symptoms. She has published seven books and over 200 journal articles and book chapters. Dr. Resick has served on the editorial boards of eight scientific journals and was an Associate Editor for the Journal of Consulting and Clinical Psychology. She has served on the Board of Directors of the International Society for Traumatic Stress Studies for nine years including terms as Secretary, Vice-President, and President (2009). She has been a Board Member for the Association for the Advancement of Behavior Therapy (now ABCT) for two terms. She served as President during 2003-2004. Dr. Resick has received numerous awards for her research, including the Robert S. Laufer Memorial Award for Outstanding Scientific Achievement in the Field of PTSD from the International Society for Traumatic Stress Studies, the 2009 Leadership Award by the Association for VA Psychologist Leaders, and the 2012 Outstanding Contributions by an Individual for Educational/ Training Activities Presented by the Association for Behavioral and Cognitive Therapies. Since 2006 she has been a leader of a national VA initiative to disseminate Cognitive Processing Therapy throughout the VA system and is currently conducting four large clinical trials at Ft. Hood, Texas. She also served on two sub-workgroups for the DSM-5.

A Brief (Not Prolonged) History of Prolonged Exposure Therapy for PTSD

Norah C. Feeny, PhD
Department of Psychological Sciences, Case Western Reserve University

Nina Rytwinski, PhD
Department of Psychological Sciences, Case Western Reserve University

After my tour in Iraq, I was just not the same person anymore. I was jumpy, uptight, and on edge all the time. Sometimes I woke up screaming. Going to crowded places was impossible—my heart would race and I'd be scanning the entire time. After being like this for several years (and with my wife's encouragement), I started prolonged exposure therapy at the VA. It was hard talking about what I'd been

through, and maybe harder to let myself connect with it. Going to crowded places was hard too—but I kept doing it; I wanted my life back. After 6 or 7 sessions, I started to notice some changes, like I was scanning less. At the end of treatment, I could sit with my memories and my nightmares had stopped. PE really helped me deal with what I'd been through in Iraq. I finally feel like myself again—maybe a changed “me,” but still me.

History of Prolonged Exposure

Prolonged exposure therapy (PE; Foa, Hembree, & Rothbaum, 2007), developed by Dr. Edna B. Foa, is one of the best empirically supported treatments for posttraumatic stress disorder (PTSD) (e.g., Bisson, 2009;

Institute of Medicine, 2008). It is a cognitive-behavioral approach to treating PTSD that involves approaching trauma-related memories and real-life feared situations. The premise is that deliberate systematic confrontation of anxiety-producing memories and situations will lead to significant reductions in anxiety and distress. Meta-analytic findings show that at the end of treatment, the average individual who received PE is faring better than 86% of waitlist control individuals (Powers, Halpern, Fereschak, Gillihan, & Foa, 2010). Thus, like the veteran in the vignette above, PE helps many individuals experience significant relief from their PTSD symptoms, even after years of suffering.

Although state-of-the-art, PE has theoretical roots dating back to the late 1940s and 1950s during the behavior therapy movement. Mowrer's (1947) two factor theory of the anxiety disorders and Wolpe's (1958) work with systematic desensitization were particularly influential. Wolpe noticed that individuals are not capable of experiencing two contradictory emotions at the same time (e.g., anxiety and relaxation). Thus, he taught his patients relaxation techniques. Then, he helped his patients create a hierarchy of feared (but objectively safe) situations. In order to overcome their fears, he encouraged patients to gradually expose themselves to the situations on their hierarchy while remaining in a relaxed state. Using this technique, he was able to successfully treat a variety of phobias. From the 1950s to the 1970s, several additional effective behavioral techniques were developed for the treatment of phobias and other anxiety disorders (e.g., flooding, Malleon, 1959; implosive therapy, Stampfl & Levis, 1976; participant modeling, Bandura, 1971). However, as noted by Marks (1973), the common element in all of these treatments was exposure to fear signals.

Coinciding with the inclusion of PTSD to the DSM-III in 1980, researchers began to study the use of exposure therapy for PTSD. Keane and colleagues (e.g., Keane, Fairbank, Caddell, & Zimering, 1989), for example, began researching the use of exposure therapy in Vietnam veterans with PTSD. After teaching their patients several relaxation techniques, therapists encouraged their patients to expose themselves to their trauma memories, starting with the least distressing scene, and gradually proceeding to the most distressing memory. The goal was to stay with each aspect of the trauma memory until it no longer elicited intense anxiety. This treatment led to significant reductions in PTSD symptoms. However, Keane and colleagues (1989)

noted that while exposure was effective at reducing re-experiencing symptoms, social avoidance and numbing symptoms remained significantly elevated. Based on this finding, they suggested that comprehensive PTSD treatment should combine exposure therapy with skills training to improve social competence.



Norah C. Feeny, PhD



Nina Rytwinski, PhD

Edna Foa and colleagues, who were using exposure therapy for rape survivors with PTSD, suggested that in addition to using exposure techniques to address the traumatic memory, exposure should be used to address the things, people, and places that individuals with PTSD are avoiding due to the traumatic memory. Thus, in PE, patients are encouraged to approach feared (but objectively safe) stimuli through two different techniques, *in vivo* exposure and imaginal exposure. In a series of randomized controlled trials, Foa and colleagues (Foa et al., 1991, 1999, 2005) established the initial efficacy of PE for assault-related PTSD.

In vivo exposure involves having the patient expose themselves to feared situations that are objectively safe in a gradual and systematic manner. However, unlike systematic desensitization, the goal is not to stay relaxed during the exposure. Instead, the patient is asked to feel the anxiety or distress associated with the situation. If the patient stays in the situation long enough his or her distress will begin to subside. And with repeated exposures, his or her anxiety and distress will be significantly reduced. Thus, near the start of treatment patients work with their therapists to create a hierarchy of feared situations. Then they begin to practice doing the things that are on their hierarchy, beginning with the moderately feared items and gradually moving up the hierarchy. For example, the veteran in the opening paragraph described a fear of going to crowded places and he basically avoided all places because they "might" be busy.

Thus, for *in vivo* homework assignments, his therapist had him practice repeatedly going to the supermarket. At the start of treatment he might practice going to the market with a good friend during a time when it is not at its busiest. Once he is able to do that with reduced distress, he might start practicing going by himself. Next, he might practice going to the market repeatedly at the busiest times by himself. Over time, the idea is that he will learn that nothing bad happens when he goes to the supermarket, and that he can handle it, and maybe even that it feels good to get out of the house.

Imaginal exposure, on the other hand, involves repeatedly telling, or revisiting, the story of the trauma.

With repeated exposures, the patient will learn several different things, including the fact that nothing bad happens when they think about the trauma memory (e.g., that they do not lose control). Furthermore, with repeated repetitions they will notice that their distress is reduced (i.e., that anxiety cannot last forever). Finally, in discussing their trauma memory they may be able to think about the trauma in a new, more adaptive manner. For example, following a trauma, patients often develop unhelpful views of themselves (e.g., “I’ll never be myself again”), others (e.g., “Always be on alert,” “No one can be trusted”), or the world (e.g., “the world is unsafe”). By discussing their trauma memory and doing the in vivo exposures, they may develop a more adaptive way of viewing these things. Ultimately, this work enables patients to think about the trauma without having intense, disruptive distress that impairs their functioning and to think about themselves and the world in a more realistic way.

Mechanism Underlying Exposure Therapy

A large body of research supports the efficacy of PE for the treatment of PTSD (see Powers et al., 2010). However, how does it work? Lang (1977) suggested that fear is represented in one’s memory as a network that includes representations of feared stimuli, fear responses, and the meaning of these stimuli and responses. According to Lang, when one attributes a threat meaning to a stimulus and response, fear occurs. Of course, in some situations, this is adaptive. For example, if you see a bear in the woods, you will experience physiological arousal, realize that you are in danger, and be motivated to escape the situation. However, in the case of phobias and other anxiety disorders, threat is connected to objectively safe stimuli (e.g., all spiders in the case of arachnophobia, or most social situations in the case of social anxiety disorder), which is not adaptive.

Foa and Kozak (1986) introduced emotional processing theory (EPT) as a framework to understand the development of pathological fear and its treatment. Specific to PTSD, Foa and colleagues (e.g., Foa, Steketee, & Rothbaum, 1989) built on EPT and suggested that in the case of PTSD a trauma memory is created that includes representations of trauma-related stimuli, responses, and their meaning. However, this trauma memory is pathological because it is made up of a particularly large number of stimuli that are associated with threat or danger and by particularly strong response elements. For example, following combat trauma, an individual with PTSD may experience intense negative reactions (e.g., sweating, shaking, heart racing) and ascribe threat to a wide variety of objectively safe stimuli that have come to be associated in their memory with the trauma (e.g., all crowded areas, driving over debris on the road, certain noises like planes flying overhead, certain smells like gasoline or a barbecue, media coverage associated with their combat experience, even the memory of the assault). Additionally, because these stimuli are now associated with danger, individuals are motivated to avoid contact with them. Unfortunately, however, by avoiding these stimuli individuals never have the opportunity to learn

that they are safe. Thus, their fear is maintained. Foa and Kozak (1986) suggested that in order for treatment to be successful, it must correct pathological elements of the fear structure. In order for this correction to occur, treatment must activate the fear memory and introduce new information that is incompatible with the pathological elements of the fear structure. This is what PE was thought to do.

Interestingly, while PE is highly effective for treating PTSD, it is also the case that fear reactions can re-occur over time (e.g., Bouton, 1988). For example, following treatment, individuals may have few PTSD symptoms and be able to do many of the things that they used to do, like going to the supermarket and driving. But, if the person stops going out or has another negative experience, that fear may reoccur, along with their other symptoms of PTSD. Based on this observation, Foa and McNally (1996) proposed that exposure therapy does not alter existing memories. Instead, it creates new, competing memories. Lang et al. (1999) explained, based on the “new theory of disuse” (Bjork & Bjork, 1992), that memories have two strengths: storage strength and retrieval strength. Storage strength is a measure of how well learned the memory is (i.e., how interassociated it is with other representations in memory). Retrieval strength is how accessible the memory representation is within memory (i.e., how easily the memory is recalled). Thus, the goal of PE is to create new memories that are well integrated into memory (i.e., have strong storage strength) and are more easily recalled (i.e., have greater retrieval strength) than the original traumatic memory. Thus, when the individual is in objectively safe situations (e.g., driving, the supermarket), memories that are associated with that being a safe place are more easily recalled than the trauma memory that associates those situations with danger.

Conclusion and Future Directions

In the past 25 years, we have amassed a large body of research demonstrating that PE is an effective treatment for PTSD and associated difficulties (see Powers et al., 2010). Building on this work, researchers have begun to incorporate the principals underlying PE in new and innovative ways (e.g., virtual reality, e.g., Rothbaum, Hodges, Ready, Graap, & Alarcon, 2001; d-cyclocerene, Litz et al., 2012; de Kleine, Hendriks, Kusters, Broekman, & van Minnen, 2012; fear inhibition learning, e.g., Norrholm et al., 2010). Ultimately, this work could enhance the treatment of PTSD. Unfortunately, despite the interest in PE among researchers, PE, along with other empirically-supported treatments for PTSD, remains severely underutilized in clinical settings (Foa, Gillihan, & Bryant, 2013). Thus, as we move forward, it will be critically important to continue dissemination efforts to ensure that this treatment is available to individuals in need (Karlson et al., 2010; McLean & Foa, 2013).

References

- Bandura, A. (1971). *Psychological modeling: Conflicting theories*. Chicago, IL: Aldine-Atherton.

- Bisson, J., & Andrew, M. (2007). Psychological treatment of post-traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews*, 18 (3), p. CD003388.
- Bjork, R.A., & Bjork, E.L. (1992). A new theory of disuse and an old theory of stimulation fluctuation. In A.F. Healy, S.M. Kosslyn, & R.M. Shiffrin (Eds.), *From learning processes to cognitive processes: Essays in honor of William K. Estes* (Vol. 2, pp. 35-67). Hillsdale, NJ: Erlbaum.
- Bouton, M. E. (1988). Context and ambiguity in the extinction of emotional learning: Implications for exposure therapy. *Behaviour Research and Therapy*, 26, 137-149.
- de Kleine, R. A., Hendriks, G. J., Kusters, W. J., Broekman, T. G., & van Minnen, A. (2012). A randomized placebo-controlled trial of D-cycloserine to enhance exposure therapy for posttraumatic stress disorder. *Biological Psychiatry*, 71, 962-968.
- Foa, E. B., Dancu, C. V., Hembree, E. A., Jaycox, L. H., Meadows, E. A., & Street, G. P. (1999). A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology*, 67, 194-200.
- Foa, E. B., Gillihan, S. J., & Bryant, R. A. (2013). Challenges and successes in dissemination of evidence-based treatments for posttraumatic stress: Lessons learned from prolonged exposure therapy for PTSD. *Psychological Science in the Public Interest*, 14, 65-111.
- Foa, E., Hembree, E., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experience therapist guide (Treatments that work)*. Oxford University Press.
- Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, 99, 20-35.
- Foa, E. B., & McNally, R. J. (1996). Mechanisms of change in exposure therapy. In R.M. Rapee (Ed.), *Current controversies in the anxiety disorders* (pp. 329-343). New York, NY: Guilford Press.
- Foa, E. B., Steketee, G., & Rothbaum, B. O. (1989). Behavioral/cognitive conceptualizations of post-traumatic stress disorder. *Behavior Therapy*, 20, 155-176.
- Institute of Medicine. (2008). *Treatment of Posttraumatic Stress Disorder: An assessment of the evidence*. Washington, DC: The National Academies Press.
- Keane, T. M., Fairbank, J. A., Caddell, J. M., & Zimering, R. T. (1989). Implosive (flooding) therapy reduces symptoms of PTSD in Vietnam combat veterans. *Behavior Therapy*, 20, 245-260.
- Lang, P. J. (1977). Imagery in therapy: An information processing analysis of fear. *Behavior Therapy*, 8, 862-886.
- Lang, A.J., Craske, M.G., & Bjork, R. (1999). Application of the new theory of disuse to long-term fear reduction. *Clinical Psychology: Science and Practice*, 6, 80-94.
- Litz, B. T., Salters-Pedneault, K., Steenkamp, M. M., Hermos, J. A., Bryant, R. A., Otto, M. W., & Hofmann, S. G. (2012). A randomized placebo-controlled trial of D-cycloserine and exposure therapy for posttraumatic stress disorder. *Journal of Psychiatric Research*, 46, 1184-1190.
- Malleon, N. (1959). Panic and phobia: A possible method of treatment. *The Lancet*, 273, 225-227.
- McLean, C. P., & Foa, E. B. (2013). Dissemination and implementation of prolonged exposure therapy for posttraumatic stress disorder. *Journal of Anxiety Disorders*. Advance online publication.
- Mowrer, O.H. (1947). On the dual nature of learning: A reinterpretation of "conditioning" and "problem solving." *Harvard Educational Review*, 17, 102-148.
- Norrholm, S. D., & Jovanovic, T. (2010). Tailoring therapeutic strategies for treating posttraumatic stress disorder symptom clusters. *Neuropsychiatric Disease and Treatment*, 6, 517-532.
- Powers, M. B., Halpern, J. M., Ferenschak, M. P., Gillihan, S. J., & Foa, E. B. (2010). A meta-analytic review of prolonged exposure for posttraumatic stress disorder. *Clinical Psychology Review*, 30, 635-641.
- Rothbaum, B. O., Hodges, L. F., Ready, D., Graap, K., & Alarcon, R. D. (2001). Virtual reality exposure therapy for Vietnam veterans with posttraumatic stress disorder. *Journal of Clinical Psychiatry*, 62, 617-622.
- Salter, A. (1949). *Conditioned reflex therapy*. New York, NY: Farrar Straus.
- Stampfl, T. G., & Levis, D. J. (1976). *Implosive therapy: A behavioral therapy*. New Jersey, NJ: General Learning Press.
- Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford Press.

Norah C. Feeny, PhD, is a clinical psychologist and a Professor in the Department of Psychological Sciences at Case Western Reserve University. She also is Director of the Case Western PTSD Treatment and Research Program. Dr. Feeny's clinical and research interests include the delivery and evaluation of cognitive behavioral treatments for PTSD. She has received funding for her work from several organizations including the National Institute for Mental Health. Dr. Feeny has published over 100 papers and chapters primarily in the area of cognitive behavioral treatment of PTSD, treatment preferences, and treatment processes.

Nina Rytwinski, PhD, completed her undergraduate studies at Queen's University in Ontario, graduate school training at Kent State University in Ohio, predoctoral internship at Eastern Virginia Medical School in Virginia, and postdoctoral fellowship at Case Western Reserve University in Ohio. Her research has largely explored factors that contribute to the onset and maintenance of mood and anxiety disorders. And her clinical work has focused on the treatment of individuals with comorbid psychological concerns and medical illnesses.

Dissemination of EBTs for PTSD: Past and Future

Josef I. Ruzek, PhD
National Center for PTSD
VA Palo Alto Health Care System

Despite progress in researching interventions for post-traumatic stress disorder (PTSD) and other trauma-related problems, evidence-based treatments (EBTs) and other best practices for PTSD have not yet been widely adopted (e.g., Rosen et al., 2004). This is not surprising, because it is only in recent times that there has been a focus on dissemination of treatments that have been demonstrated to be effective. Previously, data were lacking as to the effectiveness of needed interventions.

That remains the case with many trauma-related issues: what constitutes effective early intervention in the warzone and hospital emergency rooms, what brief PTSD interventions can be used in primary care medical settings, how should we treat concurrent PTSD and substance abuse, and so on. However, the absence of empirically-supported interventions that map onto the range of prevention and treatment environments, populations, and clinical presentations does not eliminate the need for training and dissemination. With the development of multiple clinical practice guidelines (CPGs) for PTSD, the scene has been set for more attention to dissemination.

In the field of traumatic stress, some practices have been widely distributed. These have not necessarily been EBTs, but rather consensus-based best practices that in most cases have been driven by need but have not received systematic evaluation. For example, frontline psychiatry and combat stress control are standard practice across militaries and methods of Stress Debriefing and Psychological First Aid are widely used by first responders. Some evidence-based PTSD treatments have been adopted by significant numbers of practitioners, including Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) in the U.S. Departments of Veterans Affairs (VA) and Defense (DoD) and Eye Movement Desensitization Reprocessing (EMDR) among many community-based practitioners. The National Child Traumatic Stress Network (NCTSN) has spread implementation of Trauma-Focused Cognitive Behavioral Therapy for children (TF-CBT; Cohen, Mannarino, & Deblinger, 2006). Empirically-based screening for PTSD has been implemented across the DoD and VHA. Note that some “successful” implementation efforts have meant that interventions without empirical support or, in fact, with evidence for their lack of effectiveness, have become widely practiced. Stress Debriefing is widely offered despite a substantial body of literature showing lack of effectiveness in preventing development of PTSD (Rose, Bisson, Churchill, & Wessely, 2002).



Josef I. Ruzek, PhD

Relatively little is known about how these dissemination efforts have succeeded, and the fidelity and competence with which the interventions are delivered and their impact on clinical outcomes have received little attention. There is a need to better understand these processes, if EBTs and other best practices are to spread. Strategies that require further conceptualization and research include development and dissemination of clinical practice guidelines, training methods, direct-to-consumer delivery of interventions via technology, and creation and application of dissemination infrastructures that enable and support implementation.

Clinical Practice Guidelines and Dissemination of Information

In recent years, consensus on best practices in management of PTSD has increasingly been achieved via the formulation of CPGs by such diverse groups as the American Psychiatric Association, International Society for Traumatic Stress Studies, and VA-DoD. Articulation and agreement about best practices is the first step in dissemination, and publication of CPGs can

assist in dissemination of EBTs by helping clinicians and policy-makers become aware of best practices (Susskind, Ruzek, & Friedman, 2012). But simple publication of CPGs has little direct impact on practice (Giguère et al., 2012). Most practitioners do not read guidelines and are unfamiliar with their content. For example, in a nationwide survey of clinicians serving maltreated youth, most could not distinguish evidence-based from non-evidence-based practices (Allen, Gharagozloo, & Johnson, 2012). Potentially, online resources can be used to better reach practitioners. For example, the U.S. National Center for PTSD (NCPTSD) website (www.ptsd.va.gov) reaches large numbers of practitioners and consumers, with 2.3 million site visits in 2012. Its “Clinician Trauma Update” service provides interested clinicians, via email, with brief summaries of clinically-relevant research (<http://www.ptsd.va.gov/professional/newsletters/ctu-online.asp>). Online toolkits can provide key provider groups with materials relevant to their specific roles (e.g., community-based mental health providers, <http://www.mentalhealth.va.gov/communityproviders/>; employers and employee assistance program professionals, <http://www.va.gov/vetsinworkplace/index.asp>). More systematic efforts to disseminate PTSD-related CPGs will be needed (see Creamer, Lewis, O'Donnell, Forbes, & Couineau, 2008).

Training

Training workshops have been central to spreading treatments because effective implementation requires clinicians to master new skills and EBT protocols. Training presentations and workshops are widely available and accepted as a routine part of professional behavior. However, traditional trainings are unlikely to improve skills or change practices (Jensen-Doss, Cusack, & de Arellano, 2008). Interactive workshops that include demonstration and practice of skills can increase the impact of training (e.g., Beidas & Kendall, 2010), especially when supplemented by post-training supervision (Fixsen et al., 2005). Workshops followed by supervision have been effective in transmitting skills for PTSD treatment (Foa, Hembree, Cahill, Rauch, Riggs, Feeny, & Yadin, 2005; Gillespie, Duffy, Hackmann, & Clark, 2002; Levitt, Malta, Martin, Davis, & Cloitre, 2007; Eftekhari et al., 2013). For example, rape crisis counselors trained to deliver PE achieved patient outcomes that matched or exceeded those obtained by CBT experts (Foa et al., 2005). Historically, individuals involved in development and research on specific interventions have served as trainers; this has limited the scale of training initiatives and has been a rate-limiting factor in spreading the

treatments.

A relatively new development in the field of PTSD has been the initiation of large-scale training initiatives in prevention (e.g., Cornum, Matthews, & Seligman, 2011) and treatment of trauma-related problems. Training programs in the VA and DoD have sought to employ evidence-based training methods to implement PE and CPT (Karlin et al., 2010; Ruzek, Karlin, & Zeiss, 2011). To date, over 1600 clinicians have been trained in PE and over 4200 have been trained in CPT. Program evaluation has suggested significant clinical benefits among large numbers of Veterans treated for PTSD during the training process (Eftekhari et al., 2013; Chard, Ricksecker, Healy, Karlin, & Resick, 2012) with magnitudes of symptom change similar to those obtained in clinical trials.

The advent of sophisticated training programs is likely associated with several factors. The concept of evidence-based treatment has itself gradually been disseminated. With the advent of war in Iraq and Afghanistan, PTSD has become an important problem, prompting sustained efforts at improving services. CPGs for PTSD recommend EBTs, and the current generation of mental health leaders is more familiar with research on PTSD and more committed to looking at research evidence as a core element of decision-making. Recently-trained clinicians are more likely to have been exposed to EBTs. In most service systems, however, providers report difficulties in accessing training, insufficient time to learn, and concerns about the cost of training (Gray, Elhai, & Schmidt, 2007). Once formal training in graduate programs has been completed, EBT training experiences of sufficient intensity, and particularly with access to post-training supervision, are not readily available.

Web-based training, if demonstrated to be effective, can potentially provide a partial solution to this access problem (Fairburn & Cooper, 2011). This capacity is best illustrated by the online training program in Trauma-Focused Cognitive-Behavioral Therapy (<http://tfcbt.musc.edu/>), a 10-hour course that teaches an EBT for children/adolescents. The program is popular with mental health professionals (over 110,000 registered learners) and can increase knowledge (Saunders, Smith, & Best, 2010). Similar online trainings have been developed for CPT (<https://cpt.musc.edu>) and Skills Training in Affective and Interpersonal Regulation (Levitt & Cloitre, 2005; http://www.ptsd.va.gov/professional/continuing_ed/ClinSkills/STAIR_online_training.asp); PE training is under development. Despite their potential reach, there has been little evaluation of PTSD-related online trainings (Ruzek et al., 2011).

Online/Phone Delivery of EBTs

Interactive Internet-based interventions

that deliver EBTs directly to trauma survivors are being developed for prevention (e.g., Benight, Ruzek, & Waldrep, 2008; Mouthaan, Sijbrandij, Reitsma, Gersons, & Olf, 2011) and treatment of PTSD (e.g., Litz, Williams, Wang, Bryant, & Engel, 2004; Knaevelsrud & Maercker, 2010; Klein, Meyer, Austin, & Kyrios, 2011) and co-occurring alcohol abuse (Brief, Rubin, Enggasser, Roy, & Keane, 2011). If research demonstrates such interventions to be effective, they hold promise of accelerating dissemination of EBTs. Smartphone applications may also help disseminate EBTs and other best practices. NCPTSD has released a freely-available app that is designed to help PTSD patients adhere to and benefit from PE (“PE Coach”; Reger, Hoffman, Riggs, Rothbaum, Ruzek, Holloway, & Kuhn, in press), with more such apps under development.

Towards Implementation Infrastructures

In most practice settings, the mechanisms required to effectively disseminate and implement practice changes largely do not exist. Ruzek and Rosen (2009) suggested that organizations should develop “dissemination infrastructures,” with components including systems/procedures for identification of dissemination priorities; marketing practices; organization or site preparation; training and supervision; systems-level intervention; measurement of practitioner behaviors and monitoring of implementation and adherence; evaluation of dissemination effectiveness; and dialogue with system practitioners and patients. Perhaps even more fundamentally:

the question is not *whether* these functions are needed to more effectively disseminate evidence-based public health interventions, but rather *who* will perform them. For the most part, they are currently unassigned (Kreuter, Casey, & Bernhardt, p. 218)

These considerations suggest that health care systems should establish centers of excellence that focus on implementation of best practices, along with standing implementation teams to work with the centers to accomplish effective practice improvement. These centers could design, direct, and evaluate implementation initiatives, starting with smaller scale pilots that could inform system-wide efforts. They could assess the complementary systems factors that must be addressed if evidence-based training is to achieve changes in practice (cf. Cohen & Mannarino, 2008; Frueh, Grubaugh, Cusack, & Elhai, 2009; Ruzek, Karlin, & Zeiss, 2011; Forbes et al., 2011; Ebert, Amaya-Jackson, Markiewicz, & Fairbank, 2012; Whitaker et al., 2012). Implementation centers would adopt a multilevel, ecological perspective that addresses interacting practitioner, training, innovation, and systems factors that can all affect uptake of new practices.

Increasing Research on Dissemination and Implementation

Trauma-related dissemination/implementation research has been increasing, with studies investigating provider and patient perceptions of assessment and treatment practices (e.g., Nelson, Shanley, Funderburk, & Bard, 2012; Forbes et al., 2010; Zoellner, Feeny, & Bittinger, 2009; attitudes towards exposure therapy have received the most research attention); perceptions of different psychosocial and pharmacological PTSD treatments (e.g., van Minnen, Hendriks, & Olf, 2010); and obstacles to effective implementation of treatments (e.g., Couineau & Forbes, 2011; Frueh, Grubaugh, Cusack, & Elhai, 2009). While this work is increasing, it has thus far focused on only a few areas of provider and patient attitudes and beliefs.

Most researchers do not feel skilled in dissemination of their findings or see it as their responsibility (National Cancer Institute, 2002; cited in Kreuter, Casey, & Bernhardt, 2012), despite calls that treatment researchers should build consideration of factors related to the transportability of their intervention into all phases of their work (McHugh & Barlow, 2012). Standard research procedures are limiting our ability to spread use of EBTs: the current model of treatment validation does not include an efficient strategy for updating EBTs, with changes introduced by users being seen as violations of the principle of replication with fidelity; and EBTs are typically designed to be diagnosis-specific, despite the fact that most clients have multiple diagnoses and problems (Rotheram-Borus, Swendeman, & Chorpita, 2012).

Conclusion

There remains a large gap between usual practices and best practices as articulated in CPGs. In the past, EBTs were learned in graduate training programs, if those programs had faculty who focused on particular research-based treatments. Now the development of CPGs is raising awareness of EBTs. Mental health leaders must ensure that their staff members are aligning their behaviors with CPGs, and, for their part, clinicians must find ways to learn EBTs and stay aware of emerging best practices. Training program and training methods must themselves become more evidence-based. Leaders must identify and address systems obstacles. Emerging perspectives of implementation science can provide approaches to changing practice that better anticipate the complexities of change. Given the scale of trauma exposure worldwide, and the limits of individual and small group treatments in reaching those needing assistance, new ways of delivering best practices that incorporate technologies require more research and development. To accelerate treatment improvement, researchers, managers, and clinicians will need to collaborate more

closely, and healthcare systems will need to develop and evaluate dissemination infrastructures that facilitate implementation of new, more effective mental health practices.

References

- Allen, B., Gharagozloo, L., & Johnson, J. (2012). Clinician knowledge and utilization of empirically-supported treatments for maltreated children. *Child Maltreatment, 24*, 11-21.
- Barlow, D. H., Farchione, T. J., Fairholme, C. P., Ellard, K. K., Boisseau, C. L., Allen, L. B., et al. (2011). *Unified protocol for the transdiagnostic treatment of emotional disorders: Therapist guide*. New York: Oxford Press.
- Beidas, R. S., & Kendall, P.C. (2010). Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. *Clinical Psychology: Science and Practice, 17*, 1-30.
- Benight, C. C., Ruzek, J. I., & Waldrep, E. (2008). Internet interventions for traumatic stress: A review and theoretically-based example. *Journal of Traumatic Stress, 21*, 513-520.
- Brief, D., Rubin, A., Enggasser, J., Roy, M. & Keane, T. (2011). Web-based intervention for returning veterans with symptoms of posttraumatic stress disorder and risky alcohol use. *Journal of Contemporary Psychotherapy, 41*, 237-246.
- Bush, N. E., Prins, A., Laraway, S., O'Brien, K., Ruzek, J., & Ciulla, R. (In press). A pilot evaluation of the Afterdeployment.org online posttraumatic stress workshop for military service members and veterans. *Psychological Trauma: Theory, Research, Practice, and Policy*.
- Chard, K. M., Ricksecker, E. G., Healy, E. T., Karlin, B. E., & Resick, P. A. (2012). Dissemination and experience with cognitive processing therapy. *Journal of Rehabilitation Research and Development, 49*, 667-678.
- Cohen, J., & Mannarino, A. P. (2008). Disseminating and implementing trauma-focused CBT in community settings. *Trauma, Violence, and Abuse, 9*, 214-226.
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford.
- Cornum, R., Matthews, M. D., & Seligman, M. E. P. (2011). Comprehensive Soldier Fitness: Building resilience in a challenging institutional context. *American Psychologist, 66*, 4-9.
- Couineau, A. & Forbes, D. (2011). Using predictive models of behavior change to promote evidence-based treatment for PTSD. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*, 266-275.
- Creamer, M., Lewis, V., O'Donnell, M., Forbes, D., & Couineau, A. (2008). *From evidence to practice: Knowledge synthesis, dissemination and transfer for better PTSD treatment*. Paper presented at Annual Meeting of International Society for Traumatic Stress Studies, Chicago, IL.
- Ebert, L., Amaya-Jackson, L., Marloewicz, J., & Fairbank, J. A. (2012). Development and application of the NCCTS Learning Collaborative Model for the implementation of evidence-based child trauma treatment. In R. K. McHugh & D. H. Barlow (Eds.), *Dissemination and implementation of evidence-based psychological interventions* (pp. 97-123). Oxford, England: Oxford University Press.
- Eftekhari, E., Ruzek, J. I., Crowley, J. J., Rosen, C. S., Greenbaum, M. A., & Karlin, B. E. (2013). Effectiveness of national implementation of prolonged exposure therapy in VA care. *JAMA Psychiatry, 70*, 949-955.
- Fairburn, C. G., & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. *Behaviour Research and Therapy, 49*, 373-378.
- Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).
- Foa, E. B., Hembree, E. A., Cahill, S. P., Rauch, S. A., Riggs, D. S., Feeny, N. C., & Yadin, E. (2005). Randomized trial of prolonged exposure for PTSD with and without cognitive restructuring:

- Outcome at academic and community clinics. *Journal of Consulting and Clinical Psychology*, 73, 955-964.
- Forbes, D., Fletcher, S., Wolfgang, B., Varker, T., Creamer, M., Brymer, M. J., Ruzek, J. I., Watson, P., & Bryant, R.A. (2010). Practitioner perceptions of Skills for Psychological Recovery: A training programme for health practitioners in the aftermath of the Victorian bushfires. *The Australian and New Zealand Journal of Psychiatry*, 44, 1105-1111.
- Forbes, D., Lewis, V., Varker, T., Phelps, A., Wade, D., O'Donnell, M., Ruzek, J., Watson, P., Bryant, R.A., & Creamer, M. (2011). Psychological First Aid following trauma: Implementation and evaluation framework for high-risk organizations. *Psychiatry*, 74, 224-239.
- Frueh, B. C., Grubaugh, A. L., Cusack, K. J., & Elhai, J. D. (2009). Disseminating evidence-based practices for adults with PTSD and severe mental illness in public-sector mental health agencies. *Behavior Modification*, 33, 66-81.
- Giguère, A., Légaré, F., Grimshaw, J., Turcotte, S., Fiander, M., Grudniewicz, A., Makosso-Kallyth, S., Wolf, F. M., Farmer, A. P., & Gagnon, M-P. (2012). Printed educational materials: Effects on professional practice and healthcare outcomes. *Cochrane Database of Systematic Reviews*, Issue 10. Art. No.: CD004398. DOI: 10.1002/14651858.CD004398.pub3
- Gillespie, K., Duffy, M., Hackmann, A., & Clark, D. M. (2002). Community based cognitive therapy in the treatment of post-traumatic stress disorder following the Omagh bomb. *Behaviour Research and Therapy*, 40, 345-357.
- Gray, M. J., Elhai, J. D., & Schmidt, L. O. (2007). Trauma professionals' attitudes toward and utilization of evidence-based practices. *Behavior Modification*, 31, 732-748.
- Jensen-Doss, A., Cusack, K. J., & de Arellano, M. A. (2008). Workshop-based training in trauma-focused CBT: An in-depth analysis of impact on provider practices. *Community Mental Health Journal*, 44, 227-244.
- Karlin, B. E., Ruzek, J. I., Chard, K. M., Eftekhari, A., Monson, C. M., Hembree, E. A., Resick, P. A., & Foa, E. B. (2010). Dissemination of evidence-based psychological treatments for post-traumatic stress disorder in the Veterans Health Administration. *Journal of Traumatic Stress*, 23, 663-673.
- Klein, B., Meyer, D., Austin, D. W., & Kyrios, M. (2011). Anxiety online—a virtual clinic: Preliminary outcomes following completion of five fully automated treatment programs for anxiety disorders and symptoms. *Journal of Medical Internet Research*, 13, 1-e89. doi:http://dx.doi.org/10.2196/jmir.1918
- Knaevelsrud, C., & Maercker, A. (2010). Long-term effects of an internet-based treatment for posttraumatic stress. *Cognitive Behavior Therapy*, 39, 72-77.
- Kreuter, M. W., Casey, C. M., & Bernhardt, J. M. (2012). Enhancing dissemination through marketing and distribution systems: A vision for public health. In R. C. Brownson, G. Colditz, & E. K. Proctor (Eds.), *Dissemination and implementation research in health: Translating science to practice*. New York: Oxford University Press.
- Levitt, J. T., & Cloitre, M. (2005). A clinician's guide to STAIR/MPE: Treatment for PTSD related to childhood abuse. *Cognitive and Behavioral Practice*, 12, 40-52.
- Levitt, J. T., Malta, L. S., Martin, A., Davis, L., & Cloitre, M. (2007). The flexible application of a manualized treatment for PTSD symptoms and functional impairment related to the 9/11 World Trade Center attack. *Behaviour Research and Therapy*, 45, 1419-1433.
- Litz, B. T., Williams, L., Wang, J., Bryant, R., & Engel, C. C. (2004). A therapist-assisted Internet self-help program for traumatic stress. *Professional Psychology: Research and Practice*, 35, 628-634.
- McHugh, R. K., & Barlow, D. H. (2012). Dissemination and implementation of evidence-based psychological interventions: Current status and future directions. In R. K. McHugh & D. H. Barlow (Eds.), *Dissemination and implementation of evidence-based psychological interventions* (pp. 247-263). Oxford, England: Oxford University Press.
- Mouthaan, J., Sijbrandij, M., Reitsma, J. B., Gersons, B. P. R., & Olf, M. (2011). Internet-based prevention of posttraumatic stress symptoms in injured trauma patients: Design of a randomized controlled trial. *European Journal of Psychotraumatology*, Article 8294. doi:http://dx.doi.org/10.3402/ejpt.v2i0.8294
- Nelson, M. M., Shanley, J. R., Funderburk, B. W., & Bard, E. (2012). Therapists' attitudes toward evidence-based practices and implementation of Parent-Child Interaction Therapy. *Child Maltreatment*, 17, 47-55.
- Reger, G. M., Hoffman, J., Riggs, D., Rothbaum, B. O., Ruzek, J., Holloway, K. M., & Kuhn, E. R. (in press). The "PE Coach" Smartphone Application: An innovative approach to improving implementation, fidelity, and homework adherence during prolonged exposure. *Psychological Services*.
- Rose, S. C., Bisson, J., Churchill, R., & Wessely, S. (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews* 2002, Issue 2. Art. No.: CD000560. DOI: 10.1002/14651858.CD000560 (Retrieved online February 24, 2013).
- Rosen, C. S., Chow, H. C., Finney, J. F., Greenbaum, M. A., Moos, R. H., Sheikh, J. I., & Yesavage, J. A. (2004). VA practice patterns and practice guidelines for treating posttraumatic stress disorder. *Journal of Traumatic Stress*, 17, 213-222.
- Rotheram-Borus, M. J., Swendeman, D., & Chorpita, B. F. (2012). Disruptive innovations for designing and diffusing evidence-based interventions. *American Psychologist*, 67, 463-476.
- Ruzek, J. I., Karlin, B. E., & Zeiss, A. (2012). Implementation of evidence-based psychological treatments in the Veterans Health Administration. In R. K. McHugh & D. H. Barlow (Eds.), *Dissemination and implementation of evidence-based psychological interventions* (pp. 78-96). Oxford, England: Oxford University Press.
- Ruzek, J. I. & Rosen, R. C. (2009). Disseminating evidence-based treatments for PTSD in organizational settings: A high priority focus area. *Behaviour Research and Therapy*, 47, 980-989.
- Ruzek, J. I., Rosen, R. C., Marceau, L., Larson, M. J., Garvert, D. W., Smith, L., & Stoddard, A. (In press). Online self-administered training for post-traumatic stress disorder treatment providers: Design and methods for a randomized, prospective intervention study. *Implementation Science*.
- Saunders, B., Smith, D., & Best, C. (2010). Effectiveness of web-based training in disseminating evidence-based trauma interventions. Presentation at 26th Annual meeting of the International Society for Traumatic Stress Studies, Montreal, Canada.
- Susskind, O., Ruzek, J.I., & Friedman, M. J. (2012). The VA/DOD clinical practice guideline for management of post-traumatic stress (update 2010): Development and methodology. *Journal of Rehabilitation Research and Development*, 49, xvii-xxvii.
- van Minnen, A., Hendriks, L., & Olf, M. (2010). When do trauma experts choose exposure therapy for PTSD patients? A controlled study of therapist and patient factors. *Behaviour Research and Therapy*, 48, 312-320.
- Whitaker, D. J., Ryan, K. A., Wild, R. C., Self-Brown, S., Lutzker, J. R., Shanley, J. R., Edwards, A. M., McFry, E. A., Moseley, C. N., & Hodges, A. E. (2012). Initial implementation indicators from a statewide rollout of SafeCare within a child welfare system. *Child Maltreatment*, 17, 96-101.
- Zoellner, L. A., Feeny, N. C., & Bittinger, J. N. (2009). What you believe is what you want: Modeling PTSD-related treatment preferences for sertraline or prolonged exposure. *Journal of Behavior Therapy and Experimental Psychiatry*, 40, 455-467.

Josef I. Ruzek, PhD, is Director of the Dissemination and Training Division of the National Center for Posttraumatic Stress Disorder in the VA Palo Alto Health Care System. He is coeditor of two editions of *Cognitive-Behavioral Therapies for Trauma*, and a co-editor of *Caring for Veterans With Deployment-Related Stress Disorders: Iraq, Afghanistan, and Beyond*, published by the American Psychological Association. Dr. Ruzek is a member of the team that developed the joint *Veterans Affairs–Department of Defense Clinical Practice Guidelines for Management of Traumatic Stress*, and has been a lead for the national implementation of *Prolonged Exposure evidence-based PTSD treatment within VHA*.

Custody Evaluations, Therapy Appointments by the Court, Child Protection and Ethics

Toby Kleinman, Esq.

I have always wondered about the relationship between the psychologist's ethics and a lawyer's strategy. I have seen them collide when dealing with children in the courts. One tends to think of an expert as someone hired by a lawyer or appointed by a court to render an opinion and give testimony to the court. I would rather think of them as required to be child advocates, hired, first, to evaluate parties and children, and then to serve the welfare of children, especially where the child needs special protection.

By way of highlighting this need, I like to compare expectations of experts in other types of cases. Civil cases might involve engineers to help assess the safety of a building for example. In medical malpractice cases, where there is an injury or death, the issue is whether there is a breach of the standard of care. A physician may be a necessary expert to help a court understand the issues and liability. In criminal cases, there may be the need for an expert to do drug analysis or explain the use of radar to assist a trier of fact. In each of these cases, the expert is a part of a legal team and gives guidance to a lawyer, who may choose to use his expert's opinion, if favorable, or not, if adverse. Ultimately, the expert may testify, and a judge or jury then makes a decision.

In direct contrast, child custody cases are unique, especially when the psychologist concludes the safety of a minor may be at risk. State law and professional ethics may require disclosure of confidential information that would ordinarily remain within the control of the lawyer.

About 97% of child custody cases in family court are amicably resolved between the parents. However, within the small percentage of cases which become highly litigated, issues of violence are frequently raised. Therefore, these are the cases where a psychologist's opinion and specialized knowledge are required.

Questions arise where abuse of a child becomes a concern of the psychologist. While psychologists may be a part of a legal team, to be utilized by the lawyer in putting on his case, a psychologist also has independent ethical obligations. For example, a psychologist is a mandated reporter of abuse. Therefore, whether the

psychologist is hired by a party or ordered by a court to conduct an evaluation, the obligation to report abuse or risk thereof to a state agency remains the same. This is true even if the abusive parent hired the psychologist. The APA Practice Guidelines, <http://www.apa.org/practice/guidelines/child-custody.aspx>, make clear that for psychologists, the child's welfare is paramount when conducting child custody evaluations.



Toby Kleinman, Esq.

All reporters of child abuse remain anonymous. The questions, then, are:

1. After making a report, do psychologists have a continuing obligation of any sort to that child, to the law or to their own ethical responsibility?
2. Do psychologists who make a mandated report of abuse during or after an evaluation, have any additional obligation to the child, especially where there is ongoing legal action for custody between parents?
3. If so, what type of action is both ethical and permissible at law?
4. Are there ethical or legal parameters for taking action or for inaction?
5. Is a line drawn independently to define what is required or permitted by ethics versus the law?

These are questions I find myself asking regularly. I ask because there is an innate or tacit belief that courts get it right, that judges are trained to understand children and act in their best interests. When these same courts are weighing fairness between parents, how can judges simultaneously protect the safety of a child? It is as if they are being asked to prosecute and defend the same person. The child's safety may actually end up taking a back seat.

What then can psychologists do? Where a psychologist is hired by the court, it may be easier to communicate concerns about one parent being a risk to the welfare of a child directly to the court. But where the psychologist is hired by one of the parties to the custody dispute, to communicate independently to the court would be impermissible, both ethically and legally. Action would be and should be initiated by the lawyer representing the party. But, does that action, even if taken by a lawyer, fulfill the psychologist's ethical

obligations as a psychologist? I think there must be a separate obligation.

For example, what happens where a lawyer represents the abusive parent? There are unethical psychologists who fail to report abuse, even where both their ethics and the law require them to do so, since all psychologists have the identical ethics and identical mandated reporting requirements regardless of who hires them. So as an ethical psychologist, how can you behave ethically even where hired by an abusive parent? First of all, are you violating any obligations if you take legal action to protect a child, even though the attorney has no obligation to bring his client's abusive actions to the court's attention? You must make a mandated and anonymous report. What can you do if the Child Protective Service Agency, the screening agency for child abuse, takes no action or if that action/inaction screener is inept for some reason? The dilemma is there. The answer is more difficult.

To provide a link between ethics and the law I believe that the psychologist should have everyone sign a contract before commencing an evaluation. Psychologists must maintain ethical standards during the evaluation even without this contract, but signing a contract would make the ethics and standards clear especially where it turns out that the person who hired you has been abusing a child.

The contract could be between the psychologist and the parties hiring the evaluator. The contract could detail the psychologist's ethical duty to place the child's best interests above either of the parties. It could also specify that confidentiality may be breached in order to report to CPS, if it is believed, based on evidence discovered in the process of evaluating the child, that there has been abuse or a risk of abuse. The psychologist should then also advise each party of the duty to report abuse in the general information given at the first evaluative session. The contract could also specify other conditions the psychologist requires. The contract would then be a memorandum of understanding between the parties regarding the psychologist's ethical duties and legal mandate to report, without which the evaluator would not engage in this work.

This is also true when a psychologist is appointed by the court to provide therapy for a child. The ethics of the psychologist must be adhered to, even at risk of losing the appointment by the court. Courts often do not know the ethical guidelines for psychologists and do not understand the distinctions between these and law. The psychologist has a duty to clarify this for the court and only to abide by their code of ethics—indeed to remove themselves from a case rather than to violate ethics.

The contract should permit the psychologist to go beyond what is required by ethical guidelines if,

in his opinion, it is required to seek to secure a child's welfare. Doing so would follow the ethical requirement to keep a child's welfare at a higher priority than the needs of the other parties, but also would permit him to take whatever action he thinks is appropriate based upon the information he gathers during the evaluation. If there is such a contract, there would be no negative repercussions, even if he were hired by the abusive parent. Further, he would not be violating any ethics if he took additional protective action where a child is at risk of harm by a parent and a lawyer decides not to call him as a witness.

The contract, if signed, alleviates other dilemmas. For example, where the appointment for an evaluation comes from a court and the court has taken no protective action, there may be other legally permissible actions available to the psychologist. In some jurisdictions a psychologist may ask a prosecutor to conduct an independent investigation.

Some states permit anyone with an interest in a child to initiate a child protection matter. In New Jersey, for example, a psychologist could become an "interested party" and as such actually request the child protection agency to file a child protection case, separate from a custody matter, even where the agency has not seen it sufficient to file one on its own, after a report of abuse. Indeed, the language of the statute in NJ would likely permit the psychologist himself to become a plaintiff in such a matter. There may be other states with mechanisms for similar action. Such action could not now be taken in most circumstances because of the limited parameters placed on the psychologist when entering a case. This may also be cost-prohibitive for the plaintiff psychologist if a state agency does not prosecute the claims.

Additional ethical issues are raised where the abuse has been reported and investigated by the agency and even tried by a court to conclusion and a court has found there was no abuse. In most civil or criminal cases, where a matter has been concluded through trial, the law presumes the factual issue(s) are resolved for all times. This is referred to as *Res Judicata*. *Res Judicata* would ordinarily settle the defining issues between parties. Moreover, in these civil cases, not involving child safety, the court has no special continuing obligations to the litigants.

But in a child custody or child protection matter, there is an open issue as long as there are minor children. When determining child safety, the court sits in a *parens patriae* role as the child's ultimate parent/protector. Accordingly, child abuse presents a distinct and separate risk, in that a "finding" may not resolve the issues of child safety for all time. The abuse itself may continue or injuries from past abuse may be recurring despite a case being resolved in the court.

The psychologist needs to be following his own ethical guidelines, which may not neatly coincide with what a court has already understood. When a psychologist evaluates a child or parent and finds abuse, despite what a court has found, he must be an advocate rather than a neutral observer. The first obligation is to present findings to the court. If the psychologist has clearly specified his ethical duty to place the child's welfare above the interests of any other parties, the attorneys and their clients will know in advance not to expect otherwise. The difficulty arises when the opposing attorney or the court takes action to disallow the finding of abuse.

I have seen psychologists elect to take proactive roles and lawyers look askance at this. But, if the psychologist believes a child is at risk even after a mandated report, it is important for the psychologist to understand that a state child protection agency is essentially a screening device. Where the investigator at the agency does not feel that a particular report rises to the level of abuse, the investigation may end with a screening for no further investigation. Some states permit the initial screening to rule out any investigation beyond the report. If there was a prior investigation of abuse, the new investigation may get short shrift, and in some states, they actually may turn their eyes to the other parent, about whom no concerns of abuse have ever been raised.

What then may a psychologist do? What then should a psychologist do? First and foremost, the psychologist should submit her findings of past abuse or risk of abuse to the court. Each state is unique and it is the obligation of the psychologist who works within the framework of forensics to know what legal action may be available to him. The problem is that many attorneys and courts put fairness to the parties ahead of the welfare of the child, and some psychologists behave unethically in performing child custody evaluations. Noteworthy, in all circumstances, is the risk to a career, when one steps outside the bounds of what typically goes on in the courts, even if the behavior and action is both legal and ethical. If you take independent action you may never get appointed by a court again or asked by a lawyer to do another evaluation in the future. If your practice depends primarily on family court evaluations, your livelihood may be in jeopardy. On the other hand, if you don't take action, a child may continue to be injured or fail to get the protection he needs.

I believe that expectations of what is usual in custody proceedings can change over time if psychologists take independent action for ethical reasons where child protection is an issue. I believe psychologists need to think carefully about the collision of ethics between unscrupulous attorneys who hire them and their obligation to protect a child. The ethical responsibility to give the child's welfare highest priority can be clarified in writing and agreed to by all parties in

advance of undertaking an assignment for an evaluation.

Once an evaluation is done and child abuse or risk of abuse is determined, a psychologist has statutory rules and ethical guidelines which require proactive behavior. What are some options? They can alert a pediatrician or call a prosecutor. In a worst case scenario of the psychologist hired by an abusive parent, the psychologist at minimum makes a mandated report. Thereafter, he may elect not to write a written report for the lawyer. If subpoenaed by the other attorney he would however have a duty to acknowledge opinions regarding abuse and not to attempt to protect his financial interest or the abusive parent.

Where the psychologist is hired by a protective parent and has made a mandated report, the psychologist then has additional obligations to pursue safety for the child, the basis of which is the same basis upon which mandated reports have been required by the state law in every state. That is, it is anticipated that based upon training and experience and the special circumstances, he will during the course of his evaluation be able to elicit and interpret information in ways that would otherwise be confidential and may never otherwise be reported. His unique circumstance is that he may gather together much information from his own contacts, collaterals, possibly mandated interviews with the parents and other sources and prior medical records as well as traditionally confidential communications. When a child's welfare is at stake, it is not ethical simply to be an arm of a legal team. Whether hired by good lawyers or bad, the psychologist's obligation is to do a competent and ethical evaluation. If the psychologist determines the hiring attorney is unethical, she can remove herself from the case and not remain beholden to either the lawyer or to the individual who paid for the services.

All psychologists engaged in forensic work have an independent obligation to find out the laws of the state, permissible behaviors within state boundaries, and especially, adhere to the ethical guidelines for protecting the child's welfare.

***Toby Kleinman, Esq.,** is a NJ attorney and has consulted in over 45 states. She is an Associate Editor of The Journal of Child Custody, has published articles in The New Jersey Law Journal, taught at the Harvard School of Public Health, is a director of the Leadership Council on Child Abuse and Interpersonal Violence, served as the Professional Liaison to Division 56, is on the Board of Advisors of the DV Leap at GW Law School. Ms. Kleinman has presented at IVAT, AFCC, the Battered Mothers Custody Conferences as a keynote speaker, and has trained family court judges. Ms. Kleinman has also been voted a New Jersey Super Lawyer and is called as a guest expert on network television.*

Sub-Threshold Traumas Hurt Too; Looking Through the Lens of Reproductive Medical Trauma

Robin Green, PsyD

Albert Einstein College of Medicine Department of Neurology

When people think of psychological trauma, many immediately associate it with Post Traumatic Stress Disorder (PTSD). When models of trauma exposure were first introduced, the emphasis was on war or being the victim of a violent crime or sexual assault, and the development of PTSD in the aftermath of these events. However, most recent models have recognized that traumas come in many forms, and their lasting effects are significant, even when they do not meet full PTSD criteria. For example, a patient of mine, who I will later discuss in greater detail, experienced multiple traumatic events primarily focused on difficulties conceiving. During our initial intake interview, I listened to her story and witnessed her tears as she discussed the trauma that she had endured and how she was still experiencing symptoms years later. Even though the DSM and the medical community at large had not acknowledged her experience(s) as meeting the definition of a traumatic event, her lived experience clearly warranted further diagnostic assessment and/or a trauma-focused therapeutic intervention. Using reproductive trauma as an example, this article advocates for a more expanded definition of those events that are classified as traumatic in our current diagnostic structure.

Sub-threshold PTSD refers to the experiencing of some PTSD symptoms after a traumatic event(s). However, some individuals do not endorse enough clinically significant PTSD symptoms to meet full criteria. Although it is increasingly included in the PTSD literature, no consistent definition for sub-threshold PTSD exists, and researchers have used different criteria to diagnose it (Blanchard et al., 1996; Franklin, Sheeran, & Zimmerman, 2002; Zlotnick, Franklin, & Zimmerman, 2002). In general, the number of symptoms and extent of impairment have been considered the primary criteria for defining a sub-threshold anxiety disorder. Studies have found sub-threshold PTSD, defined in several ways, to be about as common as full blown PTSD (Marshall et al., 2001). Researchers have also found that those who are diagnosed with sub-threshold PTSD have a greater likelihood of developing full blown PTSD at some point in their lives. Marshall et al.'s (2001) findings also suggest that those with a

presence of sub-threshold PTSD are at a significantly higher risk for suicidal ideation and functional impairment. This research suggests that there is a need to expand the boundaries of full criteria for PTSD towards a more dimensional model.



Robin Green, PsyD

Reproductive Trauma (RT) comes in several forms, the most common of which leave no physical scars and have no social rituals to acknowledge the event, which often leaves the victim without a way to process the emotional pain. RT can be based on events that have actually happened such as rape, stillbirth, termination of a fetus with an anomaly, difficult delivery, miscarriage, or early elective abortion. In addition, RT can stem from events that have not happened, such as not being able to conceive even with treatment. Any of these events can shake self-identity and shatter assumptions about the way the world should work. Because many of these events are taboo topics, women are often left to process the events alone. If they find themselves without a support system, many women become susceptible to heightened anxiety responses and intrusive experiences when they are in settings that remind them of the trauma. However, the diagnostic criteria for the DSM draw clear lines when detailing what constitutes a “traumatic event” and the majority of reproductive traumas do not qualify; therefore, some patients will not be appropriately identified as needing trauma-focused interventions.

Several years ago, I was referred a patient, RT, in the outpatient psychology clinic of a major teaching hospital. Her case has stuck with me throughout the years and has helped to inform my research, teaching, and supervision about the numerous ways trauma can impact a client's emotional stability and overall level of functioning. At the time of the referral, the client was “10 years” removed from the trauma she endured while trying to start a family. Her story began at the advanced reproductive age of 39, and like many women her age, she had difficulty becoming pregnant. She was eventually diagnosed with “infertility” after a battery of fertility tests. She found a clinic near where she lived and used Assisted Reproductive Techniques (ART) to try to become pregnant, and was successful after one cycle of in vitro fertilization. After 10 weeks, she was transferred from her trusted Reproductive Endocrinology and Infertility (REI) doctor to an OB/

GYN whom she had never met before. She reported that the new doctor seemed nervous, asking her repeatedly about the use of her own eggs. However, he seemed nice and she felt that she could trust him. After many doctor visits and ultrasounds, the OB/GYN nervously pushed her to have amniocentesis at 18 weeks. She had missed having the tests that are standard for a pregnant woman of her advanced age due to the gap in time between transfer from her REI to the OB/GYN. These screening tests include nuchal translucency screening and maternal blood tests to determine if the fetus might have a birth defect, such as Down syndrome, trisomy 18, or trisomy 13. She had her amniocentesis during week 20 and went home to await the results.

Just under two weeks later, while driving home from work during a blizzard, she learned that her father had died (Trauma #1). The client and her husband drove through the storm to her mother's house to be with her family and prepare to bury her father. After the funeral, wanting to lift everyone's spirits, she called her OB to find out the sex of the baby. What she did not expect was to find out that her baby had Down syndrome, Trisomy 21 (Trauma #2). After speaking with her flustered OB/GYN and her "cold and detached" REI, she sought help from medical colleagues who worked in REI. She was in a state of shock and made the decision to terminate the pregnancy, which was rushed due to her state's law banning late stage terminations (Trauma #3). One year later the client tried again and was told her eggs were too old and she would never be able to have children without the use of a donor egg program (Trauma #4). She stated that she felt that the medical community had failed her by ignoring and abandoning her while all of these terrible events were happening. She stated that she felt that she was left to suffer in silence. Ten years later, she still did not feel comfortable or safe in medical settings because they reminded her of the traumas she had endured and was often reluctant even to make routine appointments. She feared feeling trapped and unable to escape when these feelings were re-experienced. She stated that despite some brief crisis counseling early on, she has never recovered from the trauma and these events had affected her overall quality of life. By the end of our first session I had no doubt that RT had experienced multiple traumatic events that currently met criteria for sub-threshold trauma. Her reported current PTSD symptoms included feeling overwhelmed, re-experiencing memories and feeling associated with the trauma (situations, places, etc. reminded her of the experience and brought back all the feelings and thoughts associated with the experience), hyperarousal, memory, concentration and attention problems (making treatment decisions more difficult). However, due to DSM IV diagnostic constraints, I was unable to diagnose her with sub-threshold PTSD in spite of the fact that clinically I was treating her for significant trauma symptoms.

Early career clinicians understand that

infertility and its treatment can leave a mark on the patient's psyche both through extended periods of treatment or failed pregnancies, and with a hole where a baby should have been. These events do not have social processing rites, and women are often actively encouraged not to speak about the pain they have experienced. There is no memorial for a baby who has never been conceived (Bartlik, Greene, Graf, Sharma, & Melnick, 1997). So, it is up to psychologists to "bear witness to the pain" and to help the patient work through the grief and loss. Miscarriage is a common event affecting 15% of all pregnancies. It is an event that occurs without accompanying social ritual to acknowledge the loss. For most women, miscarriage is a setback but for some the impact is severe and integration of the loss into the women's life experience may be overwhelming. Grief from the loss of a spontaneous abortion, stillbirth, or medically necessary termination procedure may be linked to the trauma and intensify the re-traumatization response to related triggers. In certain cases, where termination of a much wanted baby due to fetal abnormalities has occurred, symptoms of PTSD, as well as depression, can be expected (Korenromp et al., 2005; Bowles et al., 2006).

Malterud and Thesen (2008) outlined several ways in which the "helper" can unwittingly commit unintended intimidations of the patient, including humiliation, being ignored and/or feeling abandoned after bad news/diagnosis, paternalism, and infantilization. Too often patients feel assaulted by the medical system (doctors, hospital, and insurance companies) and by their own bodies. Clinicians need to incorporate routine screening for sub-threshold trauma symptoms as well as threshold PTSD subsequent to medical trauma, specifically reproductive traumas. Screening for sub-threshold PTSD symptoms early on can help to identify patients who need trauma-based treatment that in turn can alleviate suffering and build resilience in patients. Research shows that sub-threshold trauma can be effectively treated utilizing the same clinical methods as threshold PTSD (Kornfield, Klaus, McKay, Helstrom, & Oslin, 2012). In fact, it is vital in order to prevent threshold PTSD from occurring in the future when another traumatic event is encountered. Reproductive trauma survivors often feel ostracized and need to be reassured that clinicians understand and appreciate that their trauma is legitimate. As early career psychologists, even those who do not directly work in medical settings, these are important things to take into consideration to help prevent medical traumas from happening or from patients being re-traumatized. Medical traumas can undermine trust in all helping professionals, which can decrease the likelihood the patients will actively seek services that may reduce their level of distress. Therefore, it is critical that we help educate the medical community as well as the patients, in order to reduce the chances of individuals like my client experiencing posttraumatic symptoms for extended periods of time.

References

- Bartlik, B., Greene, K., Graf, M., Sharma, G., & Melnick, H. (1997). Examining PTSD as a complication of infertility. *Medscape Women's Health eJournal*, 2(3), 1. Retrieved from <http://www.medscape.com/viewarticle/408851>.
- Blanchard, E.B., Hickling, E.J., Barton, K.A., Taylor, A.E, Loos, W.R., & Jones-Alexander, J. (1996). One-year prospective follow-up of motor vehicle accident victims. *Behavioral Research and Therapy*, 34(10), 775-786.
- Bowles, S.V., Bernard, R.S., Epperly, T., Woodward, S., Ginzburg, K., Folen, R., Perez, T., & Koopman, C., (2006). Traumatic stress disorders following first-semester spontaneous abortion. *Journal of Family Practice*, 55(11), 969-973.
- Franklin, C.L., Sheeran, T., & Zimmerman, M. (2002). Screening for trauma histories, posttraumatic stress disorder (PTSD), and subthreshold PTSD in psychiatric outpatients. *Psychological Assessment*, 14(4), 467-471.
- Korenromp, M.J., Christiaens, G.C., van den Bout, J., Mulder, E.J., Hunfeld, J.A., Bilardo, C.M., Offermans, J.P., & Visser, G.H. (2005). Long-term psychological consequences of pregnancy termination for fetal abnormality: A cross sectional study. *Prenatal Diagnosis*, 25(3), 253-260.
- Kornfield, S.L., Klaus, J., McKay, C., Helstrom, A., & Oslin, D. (2012). Subsyndromal posttraumatic stress disorder symptomatology in primary care military veterans: Treatment implications. *Psychological Services*, 9(4), 383-389.
- Malterud, K., & Thesen, J. (2008). When the helper humiliates the patient: A qualitative study about unintended intimidations. *Scandinavian Journal of Public Health*, 36(1), 92-98.
- Marshall, R.D., Olfson, M., Hellman, F., Blanco, C., Guardino, M., & Struening, E.L. (2001). Comorbidity, impairment, and suicidality in subthreshold PTSD. *American Journal of Psychiatry*, 158(9), 1467-1473.
- Zlotnick, C., Franklin, C.L., & Zimmerman, M. (2002). Does "subthreshold" posttraumatic stress disorder have any clinical relevance? *Comprehensive Psychiatry*, 43(6), 413-419.

Robin Green, PsyD, is an Assistant Professor at the Albert Einstein College of Medicine (AECOM) Department of Neurology and is a women's health researcher. She has numerous publications including scientific papers on psychosocial risk factors for disease, menopausal symptoms, infertility, and Hispanic women's health. Her dissertation investigated the phenomenon of the cardiac event as a psychological trauma in cardiac patients. She designed and implemented a brief, psychodynamic psychotherapy model for the specific treatment of the "cardiac event" with adults participating in cardiac rehabilitation during her doctoral training. She is currently funded by the National Institute on Aging to study women's health across the menopausal transition in Hispanic women. She is also conducting a prevalence study of current and lifetime sub-threshold trauma in women seeking reproductive services at AECOM and Montefiore Medical Center women's health clinics. In addition, she mentors and teaches medical students at AECOM.

Winter 2014 TPN: Call for Articles and Special Note (Change in Newsletter Editor)

Call for Articles

Trauma Psychology Newsletter is now accepting submissions for the Winter 2014 issue. All articles related to trauma psychology with a focus on theory, research, clinical or community applications, education and training, or policy will be considered. The deadline is February 1, 2014. Please limit length to 1,500-2,000 words, and send in MS Word or WordPerfect formats using APA Style. Please include a 100-word author bio at the end of the article and send a high quality photo (jpg or tiff) with your submission. Article submissions or requests for full editorial guidelines should be sent to Renu Aldrich, MA, MFTi, Editor (renu@renualdrich.com).



Simon A. Rego, PsyD

Change in Newsletter Editor

This is my last issue as editor of *Trauma Psychology Newsletter*. It's been an incredibly rewarding experience serving in this capacity over the past 2 years, and I think we've covered some very interesting and important issues related to trauma psychology. I am particularly proud and excited to end with the special section included in this issue on the history and development of trauma treatments that was guest edited by Drs. Edna Foa, Carmen McLean, and David Yusko. I want to thank Ruth Blizard, Terry Keane,



Renu Aldrich, MA, MFTi

Constance Dalenberg, Keith Cooke, and all of the *TPN* Advisory Editors, EC officers, Committee Chairs, Task Force Leaders. I'd also like to send a special thanks to all of the Editorial Assistants that have helped with the proofing. Finally, it's my pleasure to introduce the incoming newsletter editor, Renu Aldrich. You're already familiar with her work as she has been Associate Editor since I started in my role as Editor and, in fact, has been the silent force behind the scenes pulling each newsletter together and making my job so easy over the past 2 years. So, I leave you in good hands. Sincerely, Simon A. Rego.

International Committee



Elizabeth Carll, PhD



Justin Kenardy, PhD



Vincenzo G. Teran, MA

Elizabeth Carll, PhD, Chair

The mission of the International Committee is to insure that international issues are represented in Division business and policies and to foster international collaboration and communication concerning trauma related issues. The committee continues to develop a variety of activities. We also continue to actively recruit student members who will be participating in the committee activities, including conducting interviews with international trauma psychologists residing outside of the U.S.

As part of the series of interviews conducted by student members with trauma psychologists from various parts of the world, Vincenzo Teran interviewed Justin Kenardy, PhD, Director of the Centre of National Research on Disability and Rehabilitation Medicine and Professor of Medicine and Psychology at the University of Queensland, Australia. The interview is below. Previous interviews have been with trauma psychologists from Africa, Asia, and Europe.

To encourage participation of international students at the APA convention, the Division approved a \$500 student stipend and complimentary convention registration to support travel of a student from a developing country to the 2014 APA Convention in Washington, DC, who has a poster or paper accepted for the presentation at the convention. A free one year membership in Division 56 is also included. Interested candidates for the travel stipend should contact Elizabeth Carll, PhD, Chair, Division 56 International Committee, at ecarll@optonline.net.

The committee organized a symposium for the 2013 convention: "International Perspectives on Intervention and Recovery Following Violence and Disaster," which also resulted in dialogue with audience members who have worked

internationally comparing experiences.

The committee continues to collect information on international trauma psychology programs both within the U.S. and globally. If you are aware of such programs, which are university-based or established as ongoing institutes, please have them contact the committee.

Interview With Justin Kenardy, PhD by Vincenzo G. Teran, MA

Justin Kenardy, PhD, is a clinical health psychologist and Director of the Centre of National Research on Disability and Rehabilitation Medicine and Professor of Medicine and Psychology at the University of Queensland, Australia. His research and clinical interests are in the areas of anxiety and post-traumatic stress in relation to physical illness or injury, particularly among young children. Dr. Kenardy has published over 200 books, chapters and papers, and has obtained over \$43 million in competitive grants and research contracts. Dr. Kenardy earned his PhD in Psychology from the University of Queensland, in Australia and completed an Internship and Post-Doctoral Fellowship at the Stanford University School of Medicine.

Dr. Kenardy's interest in post-traumatic stress started shortly after completing his postdoctoral training in the U.S. and moving back to Newcastle, Australia. Around this time, in 1989, a major earthquake in Newcastle destroyed a significant part of the city, damaging buildings, and creating major casualties. In response, Beverly Raphael, MD, a researcher on the impact of trauma on mental health, suggested to him that he collaborate with Vaughan Carr, MD, on research

studying the psychological impact of the earthquake on the Newcastle community. The collaborative work would also examine the experience of high risk groups including first responders to the disaster.

These research findings concluded that the psychological debriefing model, which was routinely administered to first responders in the Newcastle community, was ineffective in reducing psychological distress and promoting recovery. This early experience focusing on understanding recovery from traumatic stress was the catalyst for Dr. Kenardy's fruitful career on the investigation of alternatives to debriefing models, early intervention, and prevention approaches following acute trauma.

While his work has included adults exposed to trauma, Dr. Kenardy has also focused on the early intervention and prevention of post-traumatic stress among children. Dr. Kenardy observed that significant accidents and injuries (e.g., burns and head trauma) were a common occurrence among children, especially the very young (aged six and under). Despite the relatively high frequency of such incidents among this population, he observed that their psychological impact was less studied. Subsequent research demonstrated an elevated risk for the development of post-traumatic stress from such accidents and injuries in young children.

However, unlike adults, young children may lack the verbal capacity to report symptoms of emotional distress. Although their clinical presentation may resemble what one may see in adults with acute stress disorder (e.g., heightened arousal and sleep disturbance), clinicians grapple with how to effectively identify evidence of traumatic stress among the very young. Dr. Kenardy further argues that the presentation of traumatic stress, particularly among those age three or younger, differs from those of adults. While there may be elements of PTSD, there are also aspects of a young child's clinical presentation that may not meet the criteria for PTSD, which describes typical adult symptoms. Some of Dr. Kenardy's work has informed DSM-V's Preschool Subtype of PTSD, which describes the differences in presentation.

According to Dr. Kenardy, "you're relying more on observing the behavioral expression of the emotional distress related to post-traumatic stress rather than self-report." For example, one may notice issues such as developmentally regressive behaviors, acting out behaviors, development of new phobias that may be unrelated to the trauma, sleep disturbances, and a range of other problems that may not necessarily be identified as being part of a typical adult PTSD presentation. Given the complexity of identifying and providing interventions for post-traumatic stress to pre-verbal and early-verbal children, Dr. Kenardy finds it imperative to

develop programs to identify, prevent, and help alleviate post-traumatic stress in this age group.

As part of this mission, Dr. Kenardy also stresses the education of health providers, teachers, and parents who can play an important role in early detection and intervention. This is particularly important in Australia, as the medical community at times overlooks the importance of attending to the mental health needs of individuals following acute trauma. Therefore, Dr. Kenardy recommends that the psychological impact of trauma be attended to by these care providers, as much as medical stability. One way that psychologists may help to facilitate this process is through the dissemination of psychoeducation on the psychological sequelae of trauma together with practical and effective detection of these effects to the medical community. To support this recommendation, Dr. Kenardy's research has suggested that children may show more resilience to the physical impact of acute trauma when their psychological needs are met. He suggests that in Australia and across the globe, those with expertise in trauma psychology have a responsibility to intervene proactively with information, screening, training, and early intervention.

Vincenzo G. Teran, MA, has recently completed an APA-accredited internship at the Center for Multicultural Training in Psychology at Boston University School of Medicine. He will be starting a Post-Doctoral Fellowship in Psychology at the Cambridge Health Alliance, Harvard Medical School. Vincenzo's interests are in the areas of multicultural psychology, traumatic stress, social justice, and psychodynamic psychotherapy.

Social Media News

Division 56 is now on social media! Please join us to get the latest announcements, Division 56 news and events, and related trauma psychology news.

Facebook:

<https://www.facebook.com/apadivision56>

Twitter:

<https://twitter.com/APADiv56>

LinkedIn:

go to <http://www.linkedin.com> and search in groups for Division 56

Stuck in Transition: A Personal Account of the Cultural Heritage of Trauma

By Valentina Stoycheva, MA

After weeks of countrywide civil demonstrations and six self-immolations protesting poverty in Bulgaria, government officials finally resigned in February of 2013. However, three months later, these same political figures won the emergency elections, perpetuating a state of political impasse in the country. This reflects a bitterly repeated slogan that Bulgarians from my generation, the last one to breathe the air of communism, were raised on: “Bulgarian citizens drink, complain, and curse, but do nothing to better their situation.”

The unfortunate cultural sketch may reflect the behavioral and psychological scars of adherence to a political system of oppression (communism) that left the country in a state of cultural and economic stagnation, financial crisis, and a deteriorating educational system. The scarcity of resources and opportunities forced many young people who craved personal and professional fulfillment to seek those outside of their native land. As one of them, a psychologist-in-training at that, I have often wondered how the legacy of cultural trauma impacts young immigrants from the post-communist countries. More personally, I will consider here how we have been shaped and influenced by our parents’ experiences growing up under the communist regime and our vague memories of deprivation before it collapsed.

The Past

Adam Michnick, a former Polish historian who was imprisoned for voicing his opposition to communism, said, “The worst about communism is what comes after it” (as cited in Yolova, 2012). In Bulgaria and other former Soviet countries, communism created an atmosphere wherein terror was transformed from an external reality to a haunting intrinsic state of dread (Znepolski, 2008). To this end, media and free speech censorship perpetuated an existential framework of submission to the state and prevented citizens from acquiring forbidden knowledge or ideas that could threaten the status quo. Daily living was characterized by monotony and rigidity—employed artfully by the state.

While religion had been formally rejected by Stalinist tradition, there was a progressive formalization and ritualization of politics and celebrations which, in turn, translated into an almost paranoid fear of anything new, surprising, and unpredictable. Professional advancement was only possible within the Communist party, while children and families of “enemies of the state” and dissidents were silently precluded from obtaining education or jobs (Kanev, 2007; Znepolski, 2008).



Valentina Stoycheva, MA

The link between historical struggles and the intrapersonal and familial dynamics of different peoples has been noted in the silent influence of *intergenerational transmission of trauma*, which refers to the transfer of symptoms from first-generation survivors who have experienced or directly witnessed trauma to their children and even grandchildren (Adelman, 1995; Danieli, 2003; O’Loughlin, 2011). O’Connor (1995) describes the profound psychological consequences of cultural trauma, resulting in intrapersonal characteristics such as pathological

dependency, low self-esteem, a persistent fear of being judged, and a tendency to suppress one’s feelings at all costs. Such responses to oppression (not dissimilarly to interpersonal violence) are initially adaptive. They assure one’s physical and psychological survival in the hands of a violent and controlling perpetrator (see Miller, 1994)—in this case, the omnipotent government.

However, the negative consequence of such life-saving submission is often relinquishing one’s sense of agency and hope for a better future. In a seemingly uncanny process, these psychological consequences are also powerful in second and third-generation descendants or trauma survivors. Instead of being linked to particular traumatic memories, they become deeply ingrained personality characteristics and even pathological symptoms (e.g., rigidity and fear of change, delusions or persecution, phobias and irrational fears, depression, and learned hopelessness).

In Bulgaria, I believe that such a process—the intergenerational transmission of trauma—has taken place at the cultural level. It is exemplified by the slogans, supposedly reflecting our national identity, such as the one discussed above. Reluctance to make civic choices and ambivalence towards authority may well have become permanent residents in the cultural

consciousness of Bulgarians, including those who successfully set foot in other countries after the fall of the Berlin Wall.

The Present

In a seminal paper addressing the issue of cultural trauma, Sztompka (2000) discusses the characteristics and consequences of damage inflicted to societies by major social changes. A key to the definition of the traumatic component of radical and unexpected societal change is that instead of setting society on a positive path, it causes paralysis—a loss of agency and direction. This process is not unlike what Fraiberg and her colleagues (1975) describe as a transformation of profound suffering into a silent ghost that comes back to haunt the children of trauma survivors, intangible yet lingering.

The communist regime gave rise to a number of collective traumatic symptoms which, by virtue of remaining unspoken, have now crossed over from the collective consciousness to the individual unconscious and have been incorporated into the intra-psychic reality of the new generation. These symptoms range from a loss of basic human traits like trust and agency to increased religiosity and superstition as well as collective shame and guilt. It can be argued that these symptoms have, to a large degree, prevented Bulgarians from successfully transitioning to an economically stable democratic society. Ironically, for Bulgarians like me who chose to emigrate in a desperate attempt to assert the right to choose a personal and professional path, relocation to a new reality brings a fresh set of problems perpetuating a state of choicelessness. These struggles, I have found, can activate the unconsciously inherited traumatic schemas of the past, especially within the context of higher education wherein one is expected to function proficiently within the parameters of various systems and institutions.

In exploring our experiences, I have found that many of my immigrant friends and I share particular fears and anxieties relating to intangible apprehensions of imminent catastrophes although not necessarily based on reality. For example, one common dream is a variant of being stranded in one's country of origin, unable to come back to a life painstakingly built in recipient countries. While facing the challenges of a demanding doctoral program, we are often simultaneously haunted by the ghosts of our national histories wherein one of us finds herself in a dream back "home," having forgotten her passport or other crucial paperwork that would grant reentry to her new life. While functioning at a very high level of agency and productivity, the fears of paralysis and futility of our efforts are ever present and gravely exacerbated.

Similarly, the notorious process of internship application is a symbolic transition and, as such,

triggers even more deep-seated fears. In addition to the traditional factors that delineate the boundaries of this months-long period of limbo, international students are unable to apply to a number of government-funded placements. Moreover, in order to meet various criteria for maintaining our student status, we must also renegotiate numerous parameters of the internship, like length of employment, vacation days, and a seemingly insignificant change of status that nevertheless requires several steps to be completed. The cultural heritage of trauma, then, becomes particularly potent. The necessity of navigating a complex system, yet anticipating that it will fail you at every stage can become overwhelming. A wrongfully entered digit in one of numerous documents can mean not matching, which might lead to deportation. Of course, the thought is somewhat irrational, and the demise is never that quick, yet the fear is very real.

Most of all, there is the dread of solitude in one's struggles. Communism perpetuated a feeling of cultural paranoia. It created a society wherein the establishment of micro-communities was forbidden by the party (Lindy & Lifton, 2001). This prohibition imminently bred not only fear of persecution, but also mistrust in others. In the clinical literature (e.g., Briere, 1996; Courtois, 1996; Davies & Frawley, 1994; Hermann, 1997), such disruptions can be seen in the trauma survivor's inability to perceive the world as a safe place capable of meeting his or her needs for security and nurturance. This pervasive sense of aloneness that myself and others have encountered is at least partially rooted in the old post-communist motto that our parents tried to teach us: "If you don't do it yourself, nobody will do it for you." They, of course, tried to assure our survival and possibly their own psychological redemption. Yet, the irony of communism—of this ideology based on building the "community"—is in exactly that annihilation of the basic capacity to feel understood.

In a city of immigrants (New York City), we are all struggling with difficult circumstances; yet people from my part of the world also have a profound sense of isolation. An image comes to mind of walking on a tight rope across the Grand Canyon—everyone else is watching from down below but even the most well intended encouragements can never engender a sense that the burden is shared.

Such is the heritage of cultural trauma. It has the potential to leave a society and its members in a perpetual stage of transition and isolation. For Bulgarians who remain in the country, it has resulted in decades of political and economic stagnation. For those of us who emigrated, paralysis is less often seen in personal and professional development, but is rather a psychological construct—an intangible fear of futility and imminent disasters. To heal the wounds, we have to first demystify the silence that to this day surrounds that particular period in our history, acknowledge

the legacy of the trauma, and attempt to connect to that which has been dissociated (Bromberg, 1998, 2001, 2011)—feelings of shame, hopelessness, and disillusionment.

References

- Adelman, A. (1995). Traumatic memory and the intergenerational transmission of holocaust narratives. *The Psychoanalytic Study of the Child, 50*, 343-367.
- Briere, J. (1996). *Therapy for adults molested as children: Beyond survival*. New York: Springer.
- Bromberg, P. (1998). The gorilla did it: Some thoughts on dissociation, the real, and the really real. *Psychoanalytic Dialogues, 11*, 385-404.
- Bromberg, P. (2001). *Standing in the spaces: Essays on clinical process trauma and dissociation*. New York: Routledge.
- Bromberg, P. (2011). *Awakening the Dreamer: Clinical Journeys*. New York: Routledge.
- Courtois, C. (1996). *Healing the incest wound: Adult survivors in therapy*. New York: Norton.
- Danieli, Y. (1998). *International handbook of intergenerational legacies of trauma*. New York: Springer.
- Davies, J., & Frawley, M. (1994). *Treating the adult survivor of childhood sexual abuse: A psychoanalytic perspective*. New York: Basic Books.
- Freiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery. *Journal of the American Academy of Child Psychiatry, 14*, 387-421.
- Herman, J. (1997). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror*. New York: Basic Books.
- Kanev, B. (2007). *This is my past*. Institute for the Study of the Recent Past. Retrieved from http://minaloto.org/images/contentdocs/borislav_kynev.pdf
- Lindy, J., & Lifton, R. (2001). *Beyond invisible walls: The psychological legacy of Soviet trauma, East European therapists, and their patients*. New York: Brunner-Routledge.
- Miller, A. (1994). *The drama of the gifted child: The search for the true self*. New York: Basic Books.
- O'Connor, G. (1995). *Recognizing and healing malignant shame*. Retrieved on October 25, 2010, from <http://irish-nationalism.net/showthread.php/6539-Recognising-and-Healing-Malignant-Shame>
- O'Loughlin, M. (2011). Trauma trails from Ireland's Great Hunger: A psychoanalytic inquiry. In B. Willock, R. Curtis, & L. Bohm (Eds.), *Loneliness and longings: Psychoanalytic perspectives on a crucial dimension of the human condition*.
- Sztompka, P. (2000). Cultural trauma: The other face of social change. *European Journal of Social Theory, 3*, 449-466.
- Yolova, I. (2012, July 23). *When are we going to exit the transition? Never*. Retrieved from www.pressadaily.bg
- Znepolski, I. (2008). *Bulgarian communism: Socio-cultural aspects and power trajectory*. Sofia, Bulgaria: Ciela Publishers.

Valentina Stoycheva, MA, is currently a *Psychologist-In-Training (psychology intern)* at Kings County Hospital in Brooklyn, NY. She defended her dissertation in July, 2013, and was still a doctoral candidate in *Clinical Psychology at the Derner Institute for Advanced Psychological Studies, Adelphi University*, when this article was written. Her main clinical and research interests are in the areas of profound and chronic trauma, resilience, and recovery; family dynamics; psychotherapy; and unconscious processes. She also teaches in the Master's programs in general psychology and mental health counseling at Adelphi University.

Apply for Fellow Status

We invite and encourage individuals who have “shown evidence of unusual and outstanding contributions or performance in the field of (trauma) psychology” (APA’s hallmark criterion) to apply for Fellowship status within Division 56. You must be an APA member for one year, and a current 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>. You will find everything you need to know about applying at the above APA web address.

In addition to meeting the APA criteria, applicants must meet Division 56 criteria, listed below.

For Division 56, we expect that the “unusual and outstanding contribution or performance” stated in the APA criteria for Fellow Status be specific to the field of trauma psychology. Two or more of the following may provide evidence of such distinction:

1. Being a pioneer in the recognition and application of trauma psychology.
2. Publishing important publications in the field of trauma psychology.
3. Producing consistently outstanding instructional or training programs that educate the next generation of trauma psychologists or developing important innovations in teaching or education in the field.
4. Demonstrating consistently outstanding clinical work with the traumatized as recognized by international or national groups through citations, awards, and other methods of

recognition.

5. Demonstrating consistently outstanding public service relevant to trauma psychology over many years that might include: (a) leadership within Division 56; (b) testimony about trauma psychology before courts and Congressional committees or government commissions; (c) service on review panels (e.g., NIH, NSF); or (d) public education/advocacy.

6. Demonstrating leadership in the area of trauma psychology across science, education, policy, and practice internationally and/or nationally.

In order to meet APA’s February deadline, Division 56 requires that all new Fellow application materials (including recommendations) be submitted through the APA website by **December 1**. This timeframe will allow our Fellow committee to review all materials, make a recommendation, and forward completed application materials to APA in time to meet their deadline.

If you are a current Fellow in another APA division, we ask for a letter describing the ways your work meets the above Division 56 Fellow criteria. We also ask for three letters of recommendation from current Fellows, at least one of which must come from a Division 56 Fellow (listed on our website at <http://www.apatraumadivision.org/honors.php>). Please submit these materials by e-mail to Laurie Pearlman (lpearlmanphd@comcast.net). We accept these applications on a rolling basis throughout the year. They do not go through the APA web-based application process.

We welcome all who are interested and qualified to apply! If you know a Division 56 member whose work meets these criteria, please encourage that person to apply.

Who's Who: Heidi Kraft, PhD

Nina K. Kominiak, BS

When psychologist Heidi Kraft, PhD, began her career, she had every intention to become a psychologist working on an organ transplant team. The call of the past changed the path she had set for herself and led her to work instead in the military setting. She wore the uniform as an active duty officer in the Navy for nearly a decade and is currently a contractor psychologist supporting various military projects. Dr. Kraft lives in San Diego with her husband and twin children.

1) What is your current occupation?

I am a clinical psychologist working as a government contractor with SAIC. I support several military projects, specifically in the realm of combat stress injuries, stigma and post-trauma growth after combat.

This position was a perfect fit for me after over nine years of active duty service in the Navy, which included, for example, a combat deployment with a Marine Corps surgical company to Iraq during the battle for Fallujah in 2004.

2) Where were you educated?

I graduated from the University of California, San Diego/San Diego State University Joint Doctoral Program in clinical psychology, and specialized in behavioral medicine. I had every intention of becoming a transplant psychologist, as that was the work I enjoyed the most during my doctoral training. Furthermore, I completed my internship at Duke Medical Center, where I spent the majority of my time on the heart and lung transplant team.

Funny how life changes your path though. I was called to serve my country in the Navy, and here I am—doing absolutely nothing related to cardiac or pulmonary medicine.



Heidi Kraft, PhD



Nina K. Kominiak, BS

3) Why did you choose this field?

Truthfully, the field chose me. As I mentioned, my plan was definitely to finish a fellowship at Duke and go on to work at a huge hospital somewhere as the psychologist on a transplant team. I absolutely loved that work.

Somewhere along the way, the motivation to follow my father's footsteps in the Navy became too strong to ignore. My work during the first seven years in the Navy (before the war in Iraq) included general psychology, with an emphasis on behavioral medicine whenever possible as well as flight psychology. I had the unique and wonderful opportunity to serve in the Navy as a flight psychologist, which meant I got to go to Flight Surgeon school, learn the basics about flight school, and then be assigned to a flying community where I was able to log flight time. It was a dream come true, since I had always loved aviation.

Then the country went to war, and those of us who wear the uniform as Navy medical providers know that if the Marines go to combat they will take their Navy Medicine personnel with them. My combat tour in Iraq with the Marines was the best and worst time in my life often in the same moment. I learned so much about myself as a psychologist, about the power of trauma and growth after injury, and about the strength we somehow find to journey on. In Iraq, I knew my path had been defined for me for the rest of my professional career.

4) What is most rewarding about this work for you?

I am blessed to work with many motivated patients who take their trauma treatment very seriously. They want to feel better and get back to their comrades. I love that our treatment for trauma really does work, that I can tell my patients that they will get better, and that so many of them actually do. I love seeing the light in their eyes again after years of the numbness and anger that is combat trauma.

5) What is most frustrating about your work?

It is frustrating, and it breaks my heart, when I have a patient who is just not ready to begin trauma treatment, and he or she never comes back after that first exposure or CPT session. Having lived through a combat deployment where things got pretty grim, I have empathy for the avoidance they feel, but I also know I can help them find some relief.

It is endlessly frustrating for me when I know I could help someone, but that person is not ready to be helped.

6) How do you keep your life in balance?

While I was in the combat zone, I wrote. I wrote all the time in a series of journals that were almost illegible as they were mostly written with a headlamp on and in the complete pitch darkness during some of those chaotic times. Those journals were later consolidated and turned into a memoir that I put together as therapy and as a chronicle for my twins, who were 15 months old when I deployed. I wanted them to understand why I had to go.

Through a variety of events, that journal was published, and my book *Rule Number Two* has singlehandedly changed the way I dealt with the entire sequelae that might have faced me after my war.

Because of the book, I have been asked to provide a large number of invited presentations to a variety of audiences over the past five years. That desensitization, engagement with others who understand, and the overwhelmingly rewarding feeling that comes from giving these talks has kept my life in balance after the war. It has helped me understand so many others' experiences with combat from so many generations,

and roles, and has given me great perspective on my experience, and where we all play into helping our country's veterans to heal.

When I am not working I actively use that same great perspective to remind me that every day with my husband and children is a gift. I am as involved as possible in their sports and activities, and cherish family time, workout time, and faith time as ways to *keep my gyro caged*, as we used to say in aviation.

7) What are your plans for the future?

Rule Number Two has been a great gift of healing, both in and of itself as exposure therapy and with the opportunities it allowed for me since it was published. Many ask if there will be a rule number three ... as of now, I would have to say no. But I've also learned to never say never.

In the immediate term, I look forward to increasing my clinical load (just a little), continuing with supervision of unlicensed psychologists, and expanding my consultation role back into some behavioral medicine initiatives with our active duty populations.

Overall, I hope to always stay engaged, even part time, with patients who have lived through combat trauma, and to be a small part of their journey of healing.

Nina K. Kominiak, BS, has been working in the technology field for over a decade, holding positions in the United States as well as overseas. However, she decided to follow her calling to study psychology, fell in love with the field, and is getting ready for graduate studies in Cognitive Neurosciences. Ms. Kominiak is currently doing research on Military Spouses' Perception on PTSD and Depression as well as on Conditioned Place Preference studies about substance abuse.

Division 56 Listservs

Anyone who belongs to Division 56 is added to div56announce@lists.apa.org listserv, for news and announcements. Join any of the following lists by sending an email to listserv@lists.apa.org and typing the following in the body of the note: subscribe name (where name is the part before the @, for example, subscribe div56stu):

- div56@lists.apa.org—discussion among members
- div56childtrauma@lists.apa.org—child trauma topics
- div56dissociation@lists.apa.org—post-traumatic dissociative mechanisms development
- div56ecpn@lists.apa.org—early career psychologists networking
- div56stu@lists.apa.org—student forum

Get to Know the Division 56 Award Winners

Lifetime Achievement Award

Patricia A. Resick, PhD, ABPP, is the Director of the Women’s Health Sciences Division of the National Center for PTSD at the Veterans Affairs (VA) Boston Healthcare System. She is a Professor of Psychiatry and Psychology at Boston University. Dr. Resick received her Doctorate in Psychology from the University of Georgia. Over her career, she also served on the faculties of the University of South Dakota, the Medical University of South Carolina and the University of Missouri-St. Louis, where she held an endowed professorship. Dr. Resick has received grants from NIH, NIJ, CDC, SAMHSA, VA and DoD to provide services and conduct research on the effects of traumatic events, particularly in women, and to develop and test therapeutic interventions for PTSD. Specifically, she developed and tested Cognitive Processing Therapy, an effective short-term treatment for PTSD and corollary symptoms. She has published seven books and over 200 journal articles and book chapters. Dr. Resick has served on the editorial boards of eight scientific journals and was an Associate Editor for the *Journal of Consulting and Clinical Psychology*. She has served on the Board of Directors of the International Society for Traumatic Stress Studies for nine years, including terms as Secretary, Vice-President, and President (2009). She has been a Board Member for the Association for the Advancement of Behavior Therapy (now ABCT) for two terms, also serving as its President during 2003-2004. Dr. Resick has received numerous awards for her research, including the Robert S. Laufer Memorial Award for Outstanding Scientific Achievement in the Field of PTSD from the International Society for Traumatic Stress Studies, the 2009 Leadership Award by the Association for VA Psychologist Leaders, and the 2012 Outstanding Contributions by an Individual for Educational/Training Activities Presented by the Association for Behavioral and Cognitive Therapies. Since 2006, she has been



Patricia A. Resick, PhD, ABPP

a leader of a national VA initiative to disseminate Cognitive Processing Therapy throughout the VA system and is currently conducting three large clinical trials at Ft. Hood, Texas. She also served on two sub-workgroups for the DSM-5. Dr. Resick will be retiring from the National Center for PTSD this year. Nominees stated: “She is an outstanding individual whose exemplary work merits national recognition” and “influencing the care of victimized women worldwide.”

Outstanding Contributions to the Science of Trauma Psychology

The joint program of research of **Dan King, PhD**, and **Lynda King, PhD**, can be generally characterized by the application of contemporary methodologies (psychometric theory and techniques, research design, and statistics) to issues in trauma, PTSD, and health, most especially targeted to military veterans and their families. As quantitative psychologists, they describe their interests and products as geared “toward the translation of new methodologies from the quantitative literature for the benefit of researchers in primary content areas related to trauma, and the practical demonstration of those methodologies to substantive research questions.” For example, in an early publication (Kaylor, King, & King, 1987) they provided the first meta-analysis within the trauma and PTSD literature, comparing war veterans to others on indicators of adjustment. A supplementary review article (King & King, 1991) was guided by a Cook and Campbell quasi-experimentation framework and concerned psychometric, statistical, and design-related factors that appear to influence the validity of causal inference in the broad body of trauma research. Also, they were primary authors of the first item response theory paper in the PTSD realm (King et al., 1993) and the first confirmatory factor analysis of a measure of PTSD (King & King, 1994). They have also devoted a good deal of their efforts toward pedagogical articles to help



Dan King, PhD



Lynda King, PhD

disseminate newer methods to trauma researchers (e.g., overviews and demonstrations of structural equation modeling, growth curve analysis, item response theory, contemporary missing data techniques). Their most recent interest has been the application of dynamic longitudinal methodologies to study the long-term impact of stressful events over the lifespan. They have directed a number of projects funded by NIMH, DoD, DVA, NIJ, and other agencies to study topics that include etiological risk and resilience factors contributing to PTSD symptom severity in Vietnam and Gulf War veterans, domestic violence among Vietnam veteran families, general life adjustment and positive outcomes among veterans and repatriated prisoners of war, development and validation of the Deployment Risk and Resilience Inventory, late-onset stress symptomatology among aging military veterans, and dimensions of gender awareness (ideology, sensitivity, and knowledge) in the delivery of health care to women veterans. The Kings currently serve as “the indefatigable and irreplaceable” Associate Statistical Editors for the official journal of our division, *Psychological Trauma: Theory, Research, Practice, and Policy*.

Several nominators commented on their “steadfast commitment to individualized mentoring and to transmitting unparalleled knowledge of measurement and statistical analyses as it relates to trauma studies to our next generation of researchers and clinicians.” “They are, to use a simple but apt word, two of the kindest people I have encountered in the field of trauma psychology. They combine an approach to empirical work marked by rigor and meticulousness with an interpersonal stance that is warm and approachable.”

Outstanding Contributions to Practice in Trauma Psychology

Allan N. Schore, PhD, is on the clinical faculty of the Department of Psychiatry and Biobehavioral Sciences, UCLA School of Medicine. He is author of four volumes, *Affect Regulation and the Origin of the Self*, *Affect Dysregulation and Disorders of the Self*, *Affect Regulation and the Repair of the Self*, and *The Science of the Art of Psychotherapy*, as well as numerous articles and chapters. Over the last two decades Dr. Schore’s interdisciplinary studies have been directed towards integrating psychological and biological models of



Allan N. Schore, PhD



Terence M. Keane, PhD

emotional and social development across the lifespan. His work has been an important catalyst in the ongoing “emotional revolution” now occurring across all clinical and scientific disciplines. His activities as a clinician-scientist span from his generating interpersonal neurobiological models of the enduring impact of early attachment trauma on brain development, to theoretical developmental psychoanalytic conceptions of the early origins of the human unconscious mind, to neuroimaging research on the neurobiology of attachment and studies of borderline personality disorder, to his biological studies of relational trauma in wild elephants, and to his practice of psychotherapy over the last 4 decades. Dr. Schore is Editor of the *Norton Series on Interpersonal Neurobiology*, and a reviewer or on the editorial staff of 35 journals across a number of scientific and clinical disciplines.

Dr. Shore stated, “I am honored to receive this award, and look upon it as one of the most important accomplishments of my career. The recognition of my work by Division 56 supports my contention that neuroscience and developmental attachment theory play critical roles in trauma theory and practice. It is remarkable to think that for most of the last century, the essential problem of human trauma was mostly ignored by science, and that there was no coherent trauma theory available to clinicians. And yet today literally every therapist, of whatever theoretical persuasion, now uses trauma principles with a broad spectrum of early forming self pathologies. I not only thank but commend Division 56 for its important contributions in increasing the awareness of the very recent advances in our understanding of trauma, including early relational trauma, to not only psychology, but also to the broader culture.”

Outstanding Service to the Field of Trauma Psychology

Terence M. Keane, PhD, is Director of the National Center for PTSD-Behavioral Sciences Division and Associate Chief of Staff for Research & Development at VA Boston Healthcare System. He is Professor of Psychiatry and Assistant Dean for Research at Boston University School of Medicine. A graduate of the University of Rochester, Dr. Keane completed his

doctoral training at Binghamton University-SUNY and his internship in clinical psychology at the University of Mississippi Medical Center. Over the course of his career, he's served as President of the International Society for Traumatic Stress Studies (ISTSS), the Association of VA Psychology Leaders (AVAPL), the Division of Trauma Psychology (56), and is the current President of the Anxiety & Depression Association of America (ADAA). Dr. Keane has published thirteen edited volumes and over 275 articles and chapters on the assessment and treatment of PTSD. Beginning in the late 1970s, his earliest work in trauma formed the basis for the application of exposure therapy to PTSD and concomitantly he developed many of the key measures now used to assess trauma exposure, PTSD, and related conditions. With his colleagues at the University of Mississippi Medical Center he published the first randomized clinical trial to study the treatment of PTSD. For the past 33 years the VA, the National Institutes of Health, Department of Defense, and Substance Abuse Mental Health Services Administration (SAMHSA) have continuously supported his program of research on psychological trauma. His contributions to the field have been recognized by many honors including the Lifetime Achievement Award (2004) and the Robert Laufer Award for Outstanding Scientific Achievement (1996) from ISTSS, a J. William Fulbright Scholar Award (1993-1994), the Distinguished Research Contributions Award from the Association for Behavioral & Cognitive Therapies (ABCT; 2004); an Outstanding Research Contributions Award (2000), the Distinguished Service Award (2002), and the Harold Hildreth Award for Distinguished Public Service from the American Psychological Association (APA) and the Weisband Distinguished Alumnus Award (1998) from Binghamton University. In 2011, Dr. Keane received an Honorary Doctor of Science degree from Binghamton University, SUNY and in 2013 he received an honorary doctorate from the Massachusetts School of Professional Psychology for his major contributions to opening the field of psychological trauma to scientific inquiry. Dr. Keane is a Fellow of the American Psychological Association and the Association for Psychological Science.

Nearly everyone in Division 56 has personally benefited from his dedication, vision, collaboration,

mentorship; the field as a whole has been shaped due to his diligence and citizenship. While Dr. Keane could have won this award for so many of his contributions to our field, he is being recognized specifically for his work establishing and growing Division 56.

Early Career Award for Ethnic Minority Psychologists in Trauma Psychology



Christine L. Chee, PhD

Christine L. Chee, PhD, is the first recipient of the Early Career Award for Ethnic Minority Psychologists in Trauma Psychology and her nominator said there is no one better to be the inaugural candidate than her. Dr. Chee is a member of the Navajo Nation and a clinical psychologist at the New Mexico VA Health Care System (NMVAHCS) in Albuquerque, New Mexico, where she serves on staff in the Women's Stress Disorder Treatment Team (WSDTT) clinic. She provides evidenced-based individual and group therapy to veterans, as well as conducting psychological assessments. Her clinical training includes providing services to adolescents, adults, families, veteran patients, and indigenous communities. Dr. Chee's research interests include PTSD, Prolonged Exposure Therapy (PE), Cognitive Processing Therapy (CPT), cross-cultural mental health, healing interventions and mental health in indigenous populations, and culturally responsive program evaluation. She recently served as Project Coordinator for a Department of Defense-funded randomized clinical trial examining group delivery of evidence-based treatments for PTSD to OEF/OIF female veterans, and is currently involved in manuscript preparation of research findings. Dr. Chee is active in the community presenting information on PTSD and its affect on Native American veterans, their families and communities. She has been involved in the development and conceptualization of culturally responsive program evaluation and coordinated three National Science Foundation grant projects focused on evaluation. Dr. Chee received her PhD in Counseling Psychology from Arizona State University in December 2008.



Paul Frewen, PhD

Winner of the Outstanding Early Career Achievement in Trauma Psychology

Paul Frewen, PhD, joined the departments of

psychiatry and psychology at the University of Western Ontario in London, Ontario, Canada in September 2008. He completed his doctorate in clinical psychology at Western and his post-doctoral residency at the Royal Ottawa Mental Health Centre. He is past-chair of the Traumatic Stress Section of the Canadian Psychological Association (CPA). He received the President's Early Research Award from the CPA in 2010, and the UWO Department of Psychiatry Faculty Research Award in 2012. He has authored over 40 peer-reviewed articles on the subjects of trauma, affect regulation, mindfulness, dissociation, and the self, primarily utilizing functional neuroimaging, experimental social cognition, and psychometrics approaches. His text, *Healing the Traumatized Self: Consciousness, Neuroscience & Treatment*, co-authored with Dr. R. Lanius, is commissioned for publication within the Norton Series in Interpersonal Neurobiology in 2013. He currently has a clinical psychology practice in London, Ontario where he primarily sees adults with PTSD, dissociative disorders, and/or chronic pain disorders and principally utilizes emotion-focused and mindfulness-based approaches to psychotherapy.

Outstanding Dissertation Award

Courtney Welton-Mitchell, PhD, is an assistant professor of International Disaster Psychology in the Graduate School of Professional Psychology at the University of Denver. She is also a research associate with the Institute of Behavioral Science, Environment and Society, Natural Hazards Center at University of Colorado, Boulder. Dr. Welton-Mitchell received her PhD in Social Psychology from the University of Denver in 2012, holds two MA degrees, in social psychology and mental health counseling, and is a licensed clinician. Dr. Welton-Mitchell has coauthored articles in the areas of international disaster psychology, mental health of refugees and other forced migrants, domestic violence/intimate partner abuse, and trauma and memory, in publications such as *Forced Migration Review*, *Journal of Aggression, Maltreatment and Trauma*, *Journal of Women and Criminal Justice*, and *Journal of Applied Cognitive Psychology*. Currently she is researching psychological factors contributing to disaster preparedness in Nepal, including developing and testing a mental health integrated disaster preparedness



Courtney Welton-Mitchell, PhD



Jessica Hamblen, PhD

training curriculum. Dr. Welton-Mitchell worked for several years with the UN and other humanitarian agencies with camp-based and urban refugees in Nepal, Tanzania, and Egypt. She continues to do consultancy work for humanitarian agencies, including recently having completed a global evaluation for UNHCR of mental health needs of humanitarian aid workers, with data collection in Bangladesh and Pakistan. She conducts psychological evaluations for asylum seekers through HealthRight International, and trains graduate students and mentors clinicians in this same work. Dr. Welton-Mitchell also coordinates disaster simulations on behalf of the international disaster psychology program at the University of Denver.

Outstanding Media Contribution to the Field of Trauma Psychology

Winner 1: Jessica Hamblen, PhD, won the Outstanding Media Contribution to the Field of Trauma Psychology for her work on a PTSD awareness campaign, AboutFace (<http://www.ptsd.va.gov/apps/AboutFace/>). Dr. Hamblen is the Deputy Director for Education at the National Center for Posttraumatic Stress Disorder and Assistant Professor of Psychiatry at the Geisel School of Medicine at Dartmouth. In her role as Deputy Director for Education she oversees the National Center's educational portfolio. The Center's educational mission is to improve PTSD outcomes by developing and disseminating authoritative information and programs on PTSD and related conditions, synthesized from published scientific research and collective experience to clinicians, researchers, Veterans, and the general public. Dr. Hamblen's research interests are in developing, disseminating, and evaluating cognitive behavioral treatments for PTSD and related conditions. She is currently funded to conduct a randomized controlled trial of CBT for Veterans with PTSD and co-occurring substance use disorders.

Dr. Hamblen wrote, "It is an honor to receive the Division 56 Outstanding Media Contributions to Trauma Psychology Award for AboutFace. AboutFace is a public awareness campaign designed to help veterans recognize their PTSD and to motivate them to seek evidence based treatment. If you come to the

site you are introduced to a community of veterans who have struggled with posttraumatic stress disorder (PTSD) and turned their lives around with treatment. Through personal testimonials, viewers meet veterans and hear how PTSD has affected them and their loved ones. In the coming months, testimonials from additional veterans, family members, and clinicians will be added to the site as well as longer individual success stories. It has been an incredible project to work on and I am privileged to work with Vicky Bippart, our director, and her team of colleagues. You can tell immediately that Vicky connected with the veterans, and visitors to the site benefit by hearing honest, direct, and intimate stories from the veterans she interviewed. I hope this award will bring new viewers to the site and am looking forward to sharing the award with the veterans who have taken the risk of sharing their stories for the benefit of helping others.”

Winner 2: Alex Kotlowitz

is a journalist who has dedicated a portion of his career depicting the role of psychological traumatization and its connection to violence. His nomination letter said “Without speaking in clinical terms or relying on clinical ‘talking heads,’ Mr. Kotlowitz evocatively and effectively conveys the clinical realities of those touched by violence.” He was nominated and won this award for his recent work on three episodes of Public Radio’s *This American Life* and a related opinion piece in the *New York Times*. On *This American Life*, “Harper High School,” Parts 1 and 2 depict the role of violence in a Chicago public school through a trauma lens. *This American Life* segment “In Country, In City” poignantly examines the parallels of two traumatized men, one a veteran of combat in Afghanistan and the other a survivor of the violent streets of Philadelphia. Finally his *New York Times* opinion piece from February 23rd, 2013, depicts the price of public violence. He writes “But missing from this conversation is any acknowledgment that the violence eats away at one’s soul—whether you’re a direct victim, a witness or, like Anita Stewart, simply a friend of the deceased. Most suffer silently. By themselves. Somewhere along the way, we need to focus on those left behind in our cities whose very character and sense of future have been

altered by what they’ve experienced on the streets.” He is honored to receive this award from the division.

Presidential Award



Alex Kotlowitz



Frank Putnam, MD

This year, President Constance Dalenberg created a Presidential Award to honor **Frank Putnam, MD**. Dr. Putnam has conducted pioneering work on understanding and assessing dissociation and is widely regarded as one of the founding fathers of the field of dissociative disorder studies. In his longitudinal work on child abuse, he was among the first to show the enduring neurobiological impact of child abuse. He has continued to help clinicians in the community use evidence-based practices to respond to child abuse. Further he has been a consistent mentor and collaborator with countless trauma psychologists. Dr. Putnam wrote, “It is a great honor to receive the American Psychological Association’s Presidential Award for Trauma. I have had the privilege and good fortune to collaborate with a number of outstanding psychologists over the course of my career including Penelope Trickett, Jennie Noll, Robert Ammerman, Eve Carlson, George Bonnano, Bethany Brand, Barbara Boat, and Pamela Cole among others. They taught me a great deal as well as being among the most stimulating, creative and generous colleagues I know. Thank you for this great honor. Please also know that I’ve had fun teasing my psychiatrist friends about my award from the APA—No, it’s from he BIG APA.”

The awards committee consisted of Mira Brancu, Charles Figley (co-chair), Elana Newman (chair) and Karen Saakvitne. The awards committee would like to thank everyone who nominated candidates

and encourage everyone to nominate colleagues next year including those candidates who did not win who are still eligible in those categories—second or third year in a row can be a charm. We have so many talented people in this division, tough choices had to be made! All the committee members agreed that it is a profound honor to serve on awards committees to learn about the wonderful work of our colleagues. Charles Figley will be chairing the 2014 Awards Committee.

New Fellows: Monson and Cook

Candice M. Monson, PhD



Candice M. Monson, PhD

Dr. Monson is currently Professor of Psychology and Director of Clinical Training at Ryerson University in Toronto, ON, and also an Affiliate of the Women's Health Sciences Division of the U.S. VA National Center for PTSD. Her primary research, teaching, and clinical interests are in the development, testing, and dissemination of efficacious psychotherapies for trauma-related disorders.

She conducted the first randomized controlled trial of Cognitive Processing Therapy (CPT) in veterans diagnosed with military-related posttraumatic stress disorder (PTSD), which contributed to CPT's identification as a front-line recommended treatment for PTSD in a number of treatment guidelines for PTSD and dissemination of the therapy world-wide. Building on her research program on interpersonal factors in trauma recovery, she co-authored Cognitive-Behavioral Conjoint Therapy for PTSD, and a wait-list controlled trial of the therapy with a range of traumatized individuals and couples was recently published in the *Journal of the American Medical Association*.

Dr. Monson moved to Toronto just over 4 years ago, and loves the diverse and cosmopolitan nature of the city—she is currently working on her dual citizenship! Outside of work, she enjoys spending time with family and friends, especially on her boat on Lake Ontario. For those of you who are new psychologists or new to trauma psychology, Dr. Monson comments, “I hope you will be as consistently inspired as I am in bearing witness to the strength and resilience of human beings recovering from trauma.”

Joan M. Cook, PhD



Joan M. Cook, PhD

Dr. Joan Cook is an Associate Professor at the Yale School of Medicine, Department of Psychiatry, and a researcher at the VA's National Center for PTSD. Since entering the field of clinical psychology, Dr. Cook's professional endeavors have focused on three areas: older adults, traumatic stress, and the dissemination of evidence-based treatments (EBTs).

She is one of the leading national experts on older adult trauma survivors and dissemination of evidence-based treatments for PTSD. Since 2001, she has continuously received funding from the National Institute of Mental Health, serving as the principal investigator on four grants, three specifically on the implementation of EBTs. Last spring, she hosted a national consensus conference with over 60 nationally recognized psychologists, psychiatrists, and social workers entitled “*Advancing the Science of Education, Training and Practice in Trauma*” in which the group articulated interdisciplinary core competencies that mental health providers should have when working with traumatized children and adults. Over the past 20 years, Dr. Cook's clinical work has included a variety of traumatized populations, particularly combat veterans and former prisoners of war, adult survivors of childhood physical and sexual abuse, and survivors of the terrorist attacks at the former World Trade Center. She was recently appointed to the APA's Clinical Treatment Guideline Development Panel for PTSD.

Dr. Cook and her husband Jan have three small children—Mira, Everett and Wesley—who keep them very busy! Dr. Cook advises those new to trauma psychology to find and express appreciation to their mentors. Dr. Cook's mentors in the trauma field are Drs. Steven Gold and Paula Schnurr.

APA Council of Representatives: February 2013 Report

Joan M. Cook, PhD, and Sandra Mattar, PsyD

Division 56 (Trauma Psychology) lost one of their two seats on APA's Council of Representatives (COR). Thus it was decided that Joan Cook and Sandra Mattar would share the position with Joan attending the mid-year meeting and Sandra attending the session at the annual meeting.

The mid-year meeting of COR took place from February 22nd through 24th in Washington, DC. A few highlights from that meeting follow:

CEO Norman Anderson, PhD, presented information on the Association's new Center for Psychology and Health. The Center will coordinate central office activities intended to ensure psychology's position in the emerging team-focused health-care marketplace. Anderson also briefed the Council on APA activities in response to the Sandy Hook Elementary School tragedy. APA mobilized both its staff and member resources after the Sandy Hook shooting to bring psychological expertise to news coverage and White House and Congressional proposals. Two APA member groups are working on reports and/or literature reviews on the issue of gun violence prediction and prevention; a third is focusing on the role of media (most notably violent video games and other interactive media) in violence and aggression.



Joan M. Cook, PhD

APA Executive Director for Education Cynthia Belar, PhD, updated the Council on the first phase of the internship stimulus program funded by the Association.

The goal of the program is to increase the number of accredited internships and support the overall quality of graduate training. During the first phase of the program, 82 applicants sought funding and \$593,000 was distributed to 32 programs.

Steven Hollon, PhD, Chair of the APA Clinical Practice Guidelines Advisory Steering Committee reviewed the association's new process for creating guidelines. The process is based on three pillars: transparency, empirical evidence, and multidisciplinary and balanced panels writing recommendations. The steering committee will oversee the guidelines creation process and expert panels will do the actual crafting of guidelines.

Council also discussed an ongoing "makeover" of the APA Convention. Past APA Presidents and Council had previously determined that the convention would be improved by more interaction across divisions. This is consistent with the idea that APA convention is the one psychology conference that cuts across all areas of specialization. In the new model every Division will have the opportunity to complement and enhance its program beyond its minimum guaranteed hours by collaborating with other divisions.

APA Council of Representatives: August 2013 Report

Sandra Mattar, PsyD, and Joan M. Cook, PhD

The APA Council of Representatives (COR) met in beautiful Hawaii during the APA Convention this summer. The meeting was "a truly momentous occasion," according to APA's President Don Bersoff. At this meeting, Council voted to significantly reorganize the APA governing structure. The vote was a result of several years of intensive work and information gathering from numerous constituencies to figure out an effective, nimble, and sustainable way for making

decisions at APA.

Following, we share with you the vote results on the different motions and the number of votes (in favor/against/abstained):

Motion #1: Technology (163/2/0)

In order to enhance governance effectiveness, efficiency and nimbleness in addressing the future of psychology and APA, Council supports the enhanced

use of technology, in addition to face-to-face meetings, to engage members and provide increased opportunity to do the work of governance (as well as the advisory bodies).

- 1 elected directly by APAGS membership, drawn from APAGS members (APAGS Past Chair)
- 3 in the Presidential cycle

Motion #2: Leadership Development (155/8/1)

Council supports developing a process for opening, and thus broadening opportunities for leadership participation and leadership development for governance service.

Motion #3: Triage (136/20/2)

Council supports the creation of an APA governance-wide triage system to ensure that the appropriate level of governance authority addresses new items and emergent situations in a timely and comprehensive fashion, without duplicative efforts.

Motion #4: Council Purpose (144/14/3)

Council will expand its scope to also focus on directing and informing policy and ensuring APA policies are aligned with APA's mission and strategic plan. The Council will review and revise the strategic plan and identify and prioritize the major issues facing psychology and APA's efforts to fulfill its mission.

Motion #5: Fiduciary Roles (108/50/1)

Council supports delegating the authority for the following areas of fiduciary responsibility to the Board of Directors on a trial basis for a three-year period following implementation:

- Financial/budget matters
- Hiring, evaluation and support for the Chief Executive Officer
- Assuring alignment of the budget with the APA strategic plan
- Internally focused policy development

Motion #6: Board Composition (96/63/3)

Council approves the following composition for the Board of Directors:

- 6 members-at-large elected directly by membership, drawn from general membership
- 4 elected by the Council, including Secretary & Treasurer and two from Council leadership team



Sandra Mattar, PsyD

- 1 appointed by Board from the public (Public Member with needed expertise—non-voting. If made voting, would increase range to 16-19.)

- CEO in *ex officio* role

- A commitment to have at least one ECP on the Board through the Assessment of Needs and Slate Development (ANSI) process

Motion #7: Council Structure (96/66/0)

- Council believes a substantive change in Council structure is needed to be effective in the future.

On this motion, Council agreed to reconsider their preferred change structure model in its next meeting.

Motion #8: Implementation (143/12/2)

Council directs the President to appoint an Implementation Work Group (IWG) made up of 15-20 individuals who are a broadly representative group of leaders from diverse backgrounds and organizational perspectives and who shall include members of Council, the Board of Directors and other members who have relevant expertise.

In other matters, Council also approved the Telepsychology Guidelines, a new policy on accreditation and licensure. Council also reconciled APA policies on psychologists' ethical obligations regarding torture and coerced interrogations, among other items.

Most importantly for Division 56, we introduced a new business item for Council: Guidelines for Psychologists Regarding the Assessment of Trauma for Adults. The item has been assigned to several APA boards and committees for review and approval.

Finally, this will be Sandra's last Council report. Her current term as Council Representative will finish in December 2013. Joan Cook will be the only voted Division 56 representative starting in January 2014.

If you would like more information on any of these issues or would like to ask any other question, please feel free to contact us: sm26@stmarys-ca.edu or Joan.Cook@yale.edu.

Trauma Research and the Institutional Review Board, Executive Committee, Division 56, June 15, 2013

Constance Dalenberg, PhD, President, Division 56, American Psychological Association

Over the past year (2012-2013), Division 56 has received increasing complaints and concerns from faculty and student researchers who are negotiating with their Institutional Review Boards (IRBs) in trauma research. IRBs are often unaware of the research that shows that disclosure of trauma history in research settings falls under the category of minimal risk in most cases. Just as those unaware of research on suicide fear that asking questions about depression and suicide might spark a suicidal act, reviewers who are unaware of research on trauma at times believe that trauma disclosure is a negative act. Thus, IRBs at times not only block research that would meet ethical standards within the trauma field, but also might require statements in informed consents that might be damaging to trauma survivors who are research participants (such as informing them that trauma disclosure is likely to cause long term distress in some minority of cases).

The Executive Committee of Division 56 wrote the following statement to provide general information about the literature on trauma research risk. The statement is not a set of standards intended to define ethical and unethical research, is not meant to be proscriptive, and is not an official APA standard. Rather, the statement is intended to be used to provide information to researchers and IRBs who are interested in the latest information on risks of trauma research.

Social Scientists and the IRB

Social scientists in general, and trauma researchers in particular, have historically travelled a difficult road in educating and negotiating with Institutional Review Boards (IRBs). The first IRBs, initiated in 1966 by the Public Health Service, applied solely to those applying to federal grants. IRB oversight spread in the 1970s, especially after passage of the 1974 National Research Act. Social scientists, however, were vociferous in their insistence that the requirements were inappropriate and onerous for social scientists, and

compromises were reached in the 1978 recommendations by the National Commission for the Protection of Human Subjects (NCPHS). Opinion columns in influential newspapers and magazines exerted pressure on governmental agencies. In *The Nation*, an editorial concluded that “in failing to distinguish between medical injections or LSD injections and survey research or interview procedures customary in the social scientists, the proposed guidelines mark a truly terrifying extension of Federal power in American life.” In 1980, a President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research was formed, a successor to the NCPHS. The commission recommended exemptions for research involving interviews or survey procedures if (a) the participants could not reasonably be identified or (b) the research “did not deal with information which, if confidentiality were breached, could place the subjects at risk of criminal prosecution, civil liability, loss of employment, or other



Constance Dalenberg, PhD

serious adverse consequences, except in settings in which subjects may feel coerced to participate.” This understanding exempted most trauma research. The policies of many universities at the time were to allow researchers to make judgments of exempt status, with the understanding that poor application of this standard by the investigator, if discovered, would be seen as an ethics violation. Doctoral committees and candidates, not IRBs, were expected to engage in thorough ethical evaluation of the proposed project. IRBs reviewed research that involved deception, experimentation, vulnerable participant categories, or otherwise potentially risky procedures. The general standard was that competent adults could decide if they wanted to participate in experiments that involved answering questions, even about sensitive topics.

In 1993, the *Albuquerque Tribune* ran a story about 18 Americans who had been injected with plutonium as part of a government study (in the 1940s) on the effects of radiation. The publicity surrounding this scandal led to new government commissions, the creation of the National Bioethics Advisory Commission, and a re-examination of exempt studies. The scandal reawakened memories of the Tuskegee Syphilis study, in which the U.S. Public Health Service monitored the progress of syphilis in a large group of low income black

adults without telling them of their disease status or offering penicillin when it became available during the study's duration (1932-1972; see Reverby, 2009).

Gary Ellis, the recently appointed leader of the Office for Protection from Research Risks (OPRR), later recalled that at this point "it was simply not possible for OPRR to ignore research that might be ambiguous, whether it was biomedical and behavioral ... It was not possible to ignore anything" (Schrag, 2010, p. 131). The *Federal Register* stated that it would still be true that "the largest portion of social science research will not be subject to IRB review and approval" (Health and Human Services, Final Regulations Amending Basic HHS Policy, 8367). In May of 1995, Ellis announced the policy should be instructed to review every proposed study, and that investigators could not use general guidelines to decide that their projects fell under exempt status. Many universities now sign model assurances (in order to receive federal funding) that promise IRB review of all protocols, and some states also require IRB review of all human subjects research.

Recommendations to the Trauma Researcher: Cost-Benefit Ratios in Trauma Research

Trauma research can engender IRBs misunderstanding of the costs and benefits to participants in trauma research protocols. Just as societies and individuals alternately approach and back away from knowledge of trauma (a dynamic that Olafson et al. [1993] refer to as "the cycle of discovery and suppression"), well-intentioned IRBs can be expected at times to protect themselves and their communities from such knowledge. This resistance can be manifested in exaggerations of the risks of trauma research in informed consents or in taking away the right of trauma victims to voice their stories in well-consented studies (through disapproval of specific studies). Experts on IRB regulation bring up many such examples, such as Schrag's (2010) example of a colleague studying the everyday experience of children in the Sri Lankan civil war who was told not to mention violence. Division 56 graduate students have also contributed examples of seemingly extreme regulatory behavior. One IRB asked the student to forward to the IRB all tapes of fully consented trauma survivors disclosing their trauma (in a study on the nature of trauma narratives) with the rationale that some of the tapes would be deemed too traumatizing to be rated by other adults. In another example, a student was told that even asking a potential participant whether he or she would like to be in a study that contained a trauma questionnaire might be problematic (since trauma survivors might experience the request to be a part of research studies to be coercive), and proposed that the study be described in a poster on the university billboard and interested participants could volunteer. Several students have noted that their colleagues are shying away from trauma

research given the perception that IRB evaluations would be too time-consuming and restrictive. In most cases, the trauma researcher can have faith that the IRB members will be responsible in reviewing the scientific merit and feasibility of research protocols, but they cannot be expected to have detailed knowledge of the relevant research in this area.

Division 56 makes the following recommendations to facilitate gaining IRB approval for trauma research. If you can, tailor your argument and choice of sources for each of the arguments below to represent your particular sample population (e.g., students, outpatients, inpatients):

Recommendation 1. In your protocol, cite research that illustrates to your IRB that the probability that your trauma questions will unduly upset your participants is quite low. This research appears to apply to most trauma populations that have thus far been studied, but is particularly applicable to nonclinical groups. For inpatient groups, the language used in Carlson et al.'s (2003) study of trauma exposure and symptoms might be appropriate ("It is possible that some people will be upset by talking about some of the things that have happened to them in the past. But usually people do not get upset."). Exaggerating the probability of upset or implying that distress is common is not recommended.

Recommendation 2. In your protocol, cite research that illustrates that the probability that your cost-benefit ratio of your research will be positive, both in the view of typical trauma research participants and based on the broader trauma literature.

Recommendation 3. All protocols should include clear statements about methods of assuring participant autonomy. Methods of providing such assurance might include making it clear that participants may stop the process at any time and that questions can be skipped, as well as keeping client self-determination in mind when choosing how and by whom the participant is asked to join the research.

Recommendation 4. In your protocol, consider some instrument that measures the participant reaction to your study such as Newman et al.'s (2001) Reaction to Research Participation Questionnaire (RRPQ) or your own tailored questionnaire covering perceived costs, benefit, and distress together with a dynamic and individually tailored method of addressing responses to the data collection.

The general finding across research studies in non-psychiatric samples is that distress responses are infrequent, mild, and transitory. Although some studies have found that those with more severe trauma histories or those with PTSD symptoms have more

distress reactions (Galea et al., 2003; Griffin et al., 2003), emotional reactions to trauma research do not generally predict negative reactions to this research. In fact, emotion or temporary distress is at times reported to correlate *positively* with perceived importance and general positive evaluation of the research in the above studies (Kluemper & Dalenberg, in press), underlining general research findings that disclosure of trauma, although difficult, can be beneficial. Disclosure of trauma has been associated with empirically measured health benefits as well as psychological benefits (Lutgendorf & Antoni, 1999; Pennebaker, Kiecolt-Glaser, & Glaser, 1988). Among psychiatric samples, risks for outpatients appear to be low, but acutely distressed patients (hospitalized inpatients, for example) are more likely to show distress (see Carlson et al., 2003, below).

Sample studies include:

Community Samples

- Black and Black (2006, 2007): In a large scale telephone survey conducted by the Center for Disease Control and Prevention, participants were asked about their history of interpersonal violence. They were told that they could skip any question they wished, and that they could end the interview at any time. Less than 1% of the participants skipped the interpersonal violence questions, while more than 15% skipped questions about their socioeconomic status.
- Galea et al. (2005): In this large study, 5774 adults in New York City were interviewed about the September 11, 2001, terrorist attacks. During the interview, some distress was noted by 12.9% of the interviewees. However, by the time the interview was over, only 1% of those immediately distressed participants were still upset.

Challenge Tasks

- Carter-Vischer, Naugle, Bell, and Suvak (2007): In one of the most potentially upsetting experimental studies, Carter-Vischer et al. exposed their participants to highly arousing visuals (e.g., mutilated bodies) and noxious sounds (e.g., sirens), measuring physiological arousal and emotional labeling of faces. One week after the study, 94% of the participants stated that they would participate again in the study if asked at that point in time. Distress was mild and diminished over time. The authors concluded that participants may have experienced some immediate expected distress from answering trauma-specific questions, but stated that there did not appear to be residual longer lasting effects of the interview.

Undergraduates

- Cromer et al. (2006) compared distress experienced while completing self-report trauma surveys to distress experienced in everyday life. The majority of the sample (63%) reported that trauma surveys were no more distressing than other experiences in everyday life. Of those who rated trauma questioning as more distressing than the experiences of everyday life, 99% rated importance and other positive aspects of the research as outweighing the relative distress.
- DePrince and Chu (2008): Undergraduates ($n = 129$) and community sample ($n = 385$) completed questionnaires about PTSD, dissociation, and trauma history. Undergraduates' average distress scores were lower than neutral, and means from the community sample were not significantly different than neutral.
- Yeater et al. (2012): This research group gathered data from 504 young adults, explicitly asking participants to compare the distress of completing a trauma survey to the stress of everyday life, the comparison defining minimal risk in the typical IRB analysis. The surveys chosen were "the most provocative (and potentially distressing) questionnaires that we could find." The conclusion was that "despite the number, variety, and extremity of questions in the trauma-sex condition, the overwhelming majority of participants—even women who reported a history of sexual victimization—were not distressed" (p. 784). The experience of filling out questionnaires was less distressing than "normal life stressors." Filling out trauma surveys was determined to be a minimal risk activity.

Refugees

- Dyregov, Dyregov, and Raundalen (2000): Bosnian refugees (twelve adults and 14 children) were interviewed regarding traumatic life events and their experiences of the Bosnian War. Eighty-seven percent rated the experience of the interview as positive (4-5 on a 5 point scale).

Outpatients

- Edwards, Dube, Felitti, & Anda (2007): Over 30,000 members of a large HMO were asked about a wide range of health behaviors and childhood abuse experiences. Participants were given a hotline number to call if they experienced distress or upset due to filling out the questionnaires. Over a 24 month period, the hotline received no calls.

- Newman, Walker, & Gefland (1999): The authors studied 1174 women in an HMO who completed a trauma-focused health survey and a subset of 252 women who later completed a trauma-focused research interview. The majority found completing the interview and the questionnaire study to be a positive experience and did not regret participating. A large proportion reported immediate perceptions of personal gain. After 48 hours, no participants reported regret and nearly three-quarters of the sample endorsed benefit. The mean level of upset was low.

Inpatients

- Carlson et al. (2003): In a study of psychiatric inpatients, structured interviews for PTSD and childhood physical and sexual assault were administered. Interviews were stopped if the patient showed strong indications of distress regardless of the individual's willingness to continue. Interviewers discontinued 16 of the 223 evaluations. An additional 23% of those who completed the interview scored their distress at 4 or 5 on a 5 point scale. Degree of "upset" was correlated with severity of current symptoms and with severity of prior trauma.

Specific Trauma Group: Bereaved

- Runeson and Beskow (1991): In a 2-week follow up of their study on trauma survivors who had lost someone to suicide, the authors found that 83% of the participants reported increased sense of benefit compared to immediately after the interview, and 57% reported feeling better than they had felt prior to research participation. Importantly, none of the study participants reported feeling worse at follow-up than they had prior to research participation.
- Brabin & Berah (1995): Intensive interviews were conducted with 257 mothers and 160 fathers who had a stillborn baby some years earlier. Asked if the interviews were distressing and helpful/unhelpful, a small proportion found the interview distressing. Nearly all reported that it had also been helpful.

Specific Trauma Group: Motor Vehicle Accidents

- Ruzek and Zatzick (2000): The authors interviewed 117 motor vehicle accident victims regarding traumatic life events, PTSD, dissociation, and depression. Thirteen percent reported being unexpectedly upset, but 95% of participants reported that the benefits of the interview outweighed the costs of the distress and they would participate again

Empirical evaluation of the cost/benefit ratio associated with your line of research will give the clearest evidence for the participant reaction to your individualized protocols. This can be monitored during the course of the study to assure that your study is not putting participants at risk, and allow researchers to change procedures to reduce risk if ever needed.

In case of distress, researchers should show empathy to any distress that is expressed by the respondent and provide a mechanism for follow-up. Given (a) the likelihood that distress will be transitory, (b) the dangers associated with pathologizing normative transitory distress, and (c) the increase in positive reactions to research over time, a graduated response to immediate mild to moderate distress is recommended. An example would be to normalize immediate distress in a supportive manner, and to provide numbers for low-cost counseling for those who find that their distress does not dissipate quickly. For those reporting high distress, direct follow-up by the experimenter is recommended.

Greater levels of unexpected upset can be expected (according to Newman and Kaloupek's 2004 review) in instances of more severe preexisting distress, complex trauma, in cases of social vulnerability, and after more serious physical injury.

Recommendations to the Trauma Researcher: Confidentiality

Recommendation 5. Although risk of trauma disclosure is generally low, this statement presumes that the researcher has put into place a clear and workable method of protecting client confidentiality. Educate your IRB in your protocol about mandated reporting rules as well as professional ethical responsibilities for reporting in your area and reveal your plan to address this. If your research protocol includes questions on groups where there is mandated reporting in your jurisdiction (e.g., child or elder abuse, etc.), and your participants are identifiable, information should be provided to participants about whether specific or general reporting requirements apply to your protocol. If your trauma questions are more general, or not related to child/elder abuse, it is still reasonable to state that confidentiality will be protected "except as required by law."

Recommendation 6. With respect to confidentiality, it may be useful to consider the degree to which your proposed study may become identified (whether true or not) as a study of a specific group of trauma survivors. This may lead to a social risk for participants to experience stigma. This may raise two related concerns. First, a clear plan of de-identification should be presented with your protocol. Second, it may be useful to present to the IRB ways the study will protect the confidentiality of survivors during the process of the study. For example, data collection

processes should ensure that others will not be privy to information leading them to make assumptions about the participants that may be stigmatizing (e.g., identifying a specific room that will be used for individuals in Trauma Study X).

Summary

The general body of research above is consistent with a minimal risk description of most trauma-related research. Minimal risk is defined as levels of harm or discomfort that is not greater than those “ordinarily encountered in daily life or during the performance of routine physical or psychological examinations and tests” (National Commission for the Protection of Human Subjects of Behavioral Research, 1978). Thus, minimal risk does not require an absence of transitory distress. The trauma researcher is often at an advantage to those serving on Institutional Review Boards in that he or she knows the trauma literature well, and can maximize benefits and minimize risk through this knowledge. Abdicating this responsibility can lead to changes in the protocol that are well-meant, but actually increase harm. Avoiding such harm is a duty of all psychologists (*APA Code of Ethics*, Standard 3.04).

Finally, trauma researchers are often those who are facilitating the telling of a story to a supportive audience for the first time. As Becker-Blease and Freyd (2006) discuss, there is a danger in NOT telling, in facilitating silence, or in sending the message to students (and particularly to trauma victims themselves) that trauma disclosure presents a greater risk than does inhibiting disclosure. As Herman (1992) wrote:

It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear, and speak no evil. The victim, on the contrary, asks the bystander to share the burden of pain. The victim demands action, engagement, and remembering (pp. 7-8).

Finding a way to tell these stories well, to examine their meaning, and to promote the understanding necessary to prevent the further occurrence of trauma, is one purpose of trauma research. Implicit in this goal is the duty to perform the research with integrity and respect.

The following descriptions have been used by Division 56 researchers in IRB approved research.

Sample Confidentiality Plan

All participants will be assigned a participant number that will be used to identify their data collected during the course of participation in the research. Consent forms will be stored separately from other study materials. Participants' names will not be kept with

video recorded data, however, there is a possibility that participants could be identified based upon their video. Participants in the study will sign a separate consent form stating their consent for their video recorded narratives to be viewed by research participants in future studies. Video data, questionnaire data, and informed consents will be kept in separate secure locations.

The following limits to confidentiality will be given: Your data will be kept confidential and will not be released except as required by law. California law mandates the filing and reporting of reasonable suspicion of child, dependent adult, or elder abuse. Participation in this research could result in the investigator being required to report child, dependent adult, or elder abuse. If you express intentions or plans to hurt yourself or someone else, the researcher will ask you additional questions about these thoughts, and depending on the intensity, may work with you to contact your physician, family member, friend, or may work with you on a plan that includes getting you to a hospital for safety.

Sample Risk/Benefit Statement to a University IRB

Sample 1. While the majority of participants are expected to have neutral or positive experiences participating in this study, we are aware that there is the risk someone may respond negatively to being asked personal questions about traumatic events and emotional distress. A recent study (Cromer, Freyd, Binder, DePrince, & Becker-Blease, 2006) reported averages of low levels of distress (rated below “neutral” using a scale) for questions that assessed childhood abuse using a very similar form of the BBTS. Furthermore, there were no differences in distress levels between questions about GPA, body image or traumatic experiences. However, participants rated questions about trauma as more important to include in psychological research than questions about body image or grades, and their mean ratings placed trauma research in the “important” to “very important” range.

Additional published research indicates that asking these types of questions is not significantly distressing to participants, even to those who have experienced traumatic events (e.g., Carlson, Newman, Daniels, Armstrong, Roth, & Loewenstein, 2003; Kassam-Adams & Newman, 2002; Newman, Walker, & Gefland, 1999; Walker, Newman, Koss, & Bernstein, 1997). The questions asked are similar to frequently-encountered descriptions on the news and in other media.

Because of the minimal risk of this study, we do not foresee emergencies. However, participants will be given information about where they can seek help if they become distressed (they can ask questions of the PI,

go to the counseling center, etc.). We are not retaining personally identifying information, so we will not be able to follow up with participants during or after the study,

Sample 2. As compensation for participation in the research study, after completing all study procedures, participants will receive \$15 or extra credit. Because participants are freely describing their trauma history, they will have the opportunity to determine the intensity of their description or to withhold any information they do not wish to share with the interviewers. Participants will also be clearly warned that the investigators are mandated reporters and must report ongoing abuse to children/elders/dependent adults or information which suggests that children/elders/dependent adults are currently at risk. There are no direct questions on this issue on the THQ. In over 6,000 participants that have been tested to date, there have been no disclosures of unreported abuse when the warnings were given.

Participants may potentially become upset or distressed by speaking about a traumatic experience. However, previous research supports a conclusion of minimal risk in trauma survey research (Legerski & Bonnell, 2010; Ruzek & Zatzick, 2000). Additionally, research has shown that research participants report minimal distress when asked about their trauma history, and may perceive trauma questions as having greater importance and more positive cost-benefit ratings compared to other types of psychological research (Cromer, Freyd, Binder, DePrince, & Becker-Blease, 2006).

In the event that the participant shows distress, it will be reiterated that the individual has the right to discontinue the research at any time. The assessment of distress will be made again at the end of the study, through use of the RRPQ. If any participant reports negative attitudes toward the study as manifested by interview responses or scores on the RRPQ Drawbacks questions, then the participant will be further interviewed and offered a list of low cost therapy resources.

The following are summary articles that go into more detail than can be covered here. Researchers are urged to spend time thinking about and discussing this important area.

Becker-Blease, K., & Freyd, J. (2006). Research participants telling the truth about their lives: The ethics of asking and not asking about abuse. *American Psychologist, 61*, 218-226.

Collogan, L., Tuma, F., & Fleischman, A. (2004). Research with victims of disaster: Institutional review board considerations. *IRB: Ethics and Human Research, 26*, 9-11.

Legerski, J., & Bonnell, S. (2010). The risks, benefits, and ethics of trauma-focused research participation. *Ethics & Behavior, 20*, 429-442.

Newman, E. & Kaloupek, D. (2004). The risks and benefits of participating in trauma-focused research studies. *Journal of Traumatic Stress, 17*, 383-394.

Newman, E. (2008). Assessing trauma and its effects without distress: A guide to working with IRBs. *APS Observer, 21*, 1-3.

References

- Brabin, P. J., & Berah, E. F. (1995). Dredging up past traumas: Harmful or helpful? *Psychiatry, Psychology and Law, 2*, 165-171.
- Black, M., & Black, R. (2007). A public health perspective on "The Ethics of Asking and Not Asking About Abuse." *American Psychologist, 62*, 328-239.
- Black, M., Kresnow, M., Arias, T., Simon, I., & Shelley, G. (2006). Telephone survey respondents' reactions to questions regarding interpersonal violence. *Violence and Victims, 21*, 443-459.
- Carlson, E. B., Newman, E., Daniels, J. W., Armstrong, J., Roth, D., & Loewenstein, R. (2003). Distress in response to and perceived usefulness of trauma research interviews. *Journal of Trauma & Dissociation, 4*(2), 131-142.
- Carter-Vischer, R., Naugle, A., Bell, K., & Suvak, M. (2007). Ethics of asking trauma-related questions and exposing participants to arousal-inducing stimuli. *Journal of Trauma and Dissociation, 8*, 27-55.
- Cromer, L., Freyd, J. J., Binder, A. K., DePrince, A. P., & Becker-Blease, K. (2006). What's the risk in asking? Participant reaction to trauma history questions compared with reaction to other personal questions. *Ethics & Behavior, 16*, 347-363.
- DePrince, A. P., & Chu, A. (2008). Perceived benefits in trauma research: Examining methodological and individual difference factors in responses to research participation. *Journal of Empirical Research on Human Research Ethics, 3*, 35-47.
- Dyregrov, K., Dyregrov, A., & Raudalen, M. (2000). Refugee families' experience of research participation. *Journal of Traumatic Stress, 13*, 413-426.
- Edwards, V., Dube, S., Felitti, V., & Anda, R. (2007). It's ok to ask about past abuse. *American Psychologist, 62*, 327-328.
- Galea, S., Nandi, A., Stuber, J., Gold, J., Acierno, R., Best, C., Bucuvalas, M., Rudenstine, S., Boscarino, J., & Resnick, H. (2005). Participant reactions to survey research in the general population after terrorist attacks. *Journal of Traumatic Stress, 18*, 461-465.
- Griffin, M., Resick, P., Waldrop, A., & Mechanic, M. (2003). Participation in trauma research: Is there evidence of harm? *Journal of Traumatic Stress, 16*, 221-227.
- Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.
- Kassam-Adams, N., & Newman, E. (2005). Child and parent reactions to participation in research following pediatric traumatic injury. *General Hospital Psychiatry, 27*, 29-35.
- Kluemper, N., & Dalenberg, C. (in press). *Is the dissociative adult suggestible: A test of the trauma and fantasy models of dissociation*.
- Lutgendorf, S. K., & Antoni, M. H. (1999). Emotional and cognitive processing in a trauma disclosure paradigm. *Cognitive Therapy and Research, 23*(4), 423-440.
- Olafson, E., Corwin, D., & Summit, D. (1993). Modern history of child sexual abuse awareness: Cycles of discovery and suppression. *Child Abuse & Neglect, 17*, 7-24.
- Newman, E., Walker, E. A., & Gefland, A. (1999). Assessing the ethical costs and benefits of trauma-focused research. *General Hospital Psychiatry, 21*, 187-196.
- Newman, E., Willard, T., Sinclair, R., & Kaloupek, D. (2001). Empirically supported ethical research practice: The costs and benefits of research from the participants' view. *Accountability in Research, 8*, 309-329.
- Pennebaker, J.W., Kiecolt-Glaser, J.K., & Glaser, R. (1988). Disclosure of traumas and immune function: Health implications for psychotherapy. *Journal of Consulting and Clinical Psychology, 56*, 239-245.
- Reverby, S.. (2009). *Examining Tuskegee: The infamous syphilis study and its legacy*. Chapel Hill, NC: University of North Carolina Press.
- Runeson, B., & Beskow, J. (1991). Reactions of survivors of suicide victims to interviews. *Acta Psychiatrica Scandinavia, 83*, 169-183.
- Ruzek, J., & Zatzick, D. (2000). Ethical considerations in research participation among acutely injured trauma survivors: An empirical investigation. *General Hospital Psychiatry, 22*, 27-36.
- Schrag, Z. (2010). *Ethical imperialism: Institutional review boards and the social sciences, 1965-2009*. Baltimore, MD: Johns Hopkins

University Press.
Walker, E. A., Newman, E., Koss, M., & Bernstein, D. (1997). Does the study of victimization revictimize the victims? *General Hospital Psychiatry, 19*, 403-410.

Yeater, E., Miller, G., Rinehart, J., & Nason, E. (2012). Trauma and sex surveys meet minimal risk standards: Implications for Institutional Review Boards. *Psychological Science, 23*, 780-787.

Psychologists Caught in the Line of Fire: How Safe Is the NY SAFE Act?

Ani Kalayjian, PhD, and Nira Shah, MA, EdM

There has been a significant increase in discussions of gun laws as they relate to mental health practitioners within the past few years, particularly after the tragedies of individual shooters claiming many innocent lives. These horrendous events have raised questions about the need for stricter gun ownership laws as well as the role of mental health professionals in reporting clients who may be a threat to society, self, or another person. The New York State Psychological Association (NYSPA) has maintained an active dialogue about these concerns, especially with the recent implementation of the new gun laws in the state.

Mental health practitioners are ethically bound to break patient confidentiality if there is any suspicion that the patient may cause physical harm to him or herself, the practitioner, or to another person. Mental health practitioners are also legally held accountable as mandated child abuse reporters. The famous Tarasoff case in the 1970s brought to light the concern about psychologists' duty to warn others who are potentially in harm's way by a client. Yet, the liability of breaking confidentiality makes issues of confidentiality and ethical duties ambiguous and difficult to navigate. Therefore, discussions within psychological circles have raised questions about whether strong legal requirements should be put in place for mental health practitioners to inform government authorities if a patient is likely to harm himself or others. However, the obvious drawback to these efforts is that patients may be less likely to reveal thoughts of harm to the practitioner or may even refrain from seeking treatment. Also of concern is the potential

harm to the mental health practitioner after reporting a violent patient.

On January 15, 2013, New York State approved a comprehensive new gun law that includes drastic changes regarding assault weapons, ammunition sales, registration requirements, and mental health mandates. The law, called the New York Secure Ammunition and Firearms Enforcement Act of 2013 (NY SAFE Act), broadens the definition of an assault weapon and decreases the permissible size of a gun magazine from 10 to seven rounds. The law bans semiautomatic rifles that have more than one military-style feature, such as a pistol grip, folding stock, flash suppressor, thumbhole stock, bayonet mount, and a second hand grip that may be held by the non-trigger hand. Semiautomatic pistols are now also banned if they contain more than one of these features: a folding or telescoping stock, a second hand grip, the ability to accept a magazine that attaches outside the pistol grip, a shroud for the non-trigger hand, a threaded barrel for a flash suppressor, a barrel extension or forward hand grip, and a weight of 50 ounces or more. Assault weapons purchased before January 15, 2013 must be registered with the NY State Police within 12 months, and gun owners who do not comply will face a felony charge.

Additionally, handguns and semiautomatic guns are required to be recertified every five years. Registration of guns will be free of charge and reviewed through the National Instant Criminal Background Check System (NICS). Gun owners may alternatively sell their guns to a licensed dealer or someone out of state. The law also includes a stricter background check for gun and ammunition purchases even in private sales. The



Ani Kalayjian, PhD



Nira Shah, MA, EdM

authors recommend that the background check should include comprehensive psychological testing of the gun purchaser as well as testing of all members of the purchaser's household.

How does the new law change requirements for reporting clients at risk for harm to self or others? Stricter regulations have been put in place so that psychologists, therapists, physicians, nurses, and social workers are now required to report to government authorities if they believe a patient is likely to harm himself or others, which could eventually lead to a revocation of the patient's gun permit and weapons. Though reporting a patient's harm to oneself or others is an ethical duty already in place, it places a greater responsibility onto practitioners to step forward. This proposes a major change in the presumption of confidentiality and ethical considerations for mental health professionals, and there has been a strong response from psychologists to this new addition.

As stated by Dr. Paul Appelbaum, director of law, ethics, and psychiatry at Columbia University, "The people who arguably most need to be in treatment and most need to feel free to talk about these disturbing impulses, may be the ones we make least likely to do so. They will either simply not come, or not report the thoughts they have" (Ritter & Tanner, 2013). Some say therapists will not take the law seriously and will continue to handle cases as they did, keeping in mind the best interests and treatment of the patient; others say psychologists and mental health practitioners were already mindful, evaluating their clients properly and notifying authorities if a danger was suspected.

In addition to highlighting practitioner responsibility, there is a wider public health concern regarding mental illness that also needs thoughtful consideration. The more important question should be: How can we transform the stigma attached to mental illness and mental health care? Hospitals label, diagnose, and overmedicate their mentally ill; state and government institutions incarcerate them, communities isolate them, and families afraid of the stigma hide their mentally ill members. What kind of laws can we pass to create an atmosphere of acceptance of mental illnesses akin to the acceptance of most physical illnesses? When regarding how mental health is approached in the community, and how this is shifting, these questions would allow mental health and mental illness to be approached with a more comprehensive eye.

Following the tragedy at Sandy Hook Elementary School, President Obama stated: "We won't be able to stop every violent act, but if there is even one thing that we can do to prevent any of these events, we have a deep obligation, all of us, to try" (The White House Office of the Press Secretary, 2013, p. 2). President Obama's plan to better protect communities from mass trauma includes four main tasks. The first

is to close loopholes in background checks to keep guns out of dangerous hands and strengthen the background check system. A recent national survey of inmates found that only 12% of those who possessed a gun had undergone a background check. The second task is to ban military-style assault weapons and high-capacity magazines and reduce gun violence. Stronger legislation needs to be put into place to create harsh punishments for gun trafficking while gun-tracing data should be enhanced to reveal trafficking patterns and public health research needs to be implemented on the causes and prevention of gun violence, including links between video games, media images, and violence.

Third, schools must be made safer. Increasing the number of counselors and school resource officers—police officers specifically trained to work in schools—can help schools create a safer environment. In addition, schools need to implement a comprehensive emergency management plan. In May 2013, the departments of Education, Justice, Health and Human Services, and Homeland Security released a set of high-quality emergency management plans for schools, houses of worship, and higher education institutions.

Finally, President Obama is pushing for an improvement in mental health services. Studies show that 75% of mental illnesses appear by age 24; however, mental health treatment is provided to fewer than half of children diagnosable with problems. Suggestions for improving services include providing "mental health first aid" training for teachers; making sure students with signs of mental illness get referred for treatment; supporting young individuals between the ages of 16 and 25 who are at risk for mental illness, substance abuse, and suicide; and increasing the national dialogue on the topic of understanding mental health. In addition, the Affordable Health Care Act will extend health care coverage to 30 million Americans and ensure more citizens will receive mental health treatment because insurance plans will cover mental health service costs.

The American Psychological Association (APA) has responded to President Obama's plan to reduce gun violence with strong support, specifically on the issues of increasing access to mental health services, identification of youth in need of treatment, training more mental health professionals, resuming gun violence research, requiring criminal background checks for all gun sales, and ensuring health insurance plans cover mental health benefits. APA has commended the White House for recognizing that mental illness is not inevitably associated with violence and that many individuals avoid seeking treatment because of the stigma attached to therapy and the unavailability of care.

According to APA, making schools safer is also of vital importance, as is recommending that school resource officers receive mandatory training in

adolescent development. The 2006 APA report *Zero Tolerance Task Force* stated that: “In the case of school security measures and school resource officers, there are simply insufficient published data to be able to evaluate the effects or effectiveness of such measures on school safety” (Ritter & Tanner, 2013).

For many years APA has advocated for mental health parity in health insurance coverage and appreciates the president’s call to have it mandated in the Patient Protection and Affordable Care Act (PPACA), more commonly known as the Affordable Care Act. In addition to this, APA recommends that the administration also encourage state health officers to identify Medicaid mental health services as mandatory rather than optional, in order to increase access to this care.

Our organization, the Association for Trauma Outreach & Prevention (ATOP), Meaningfulworld, has worked around the globe in more than 45 disaster zones to heal survivors and conduct research on meaning, healing, and transforming violence (Kalayjian & Eugene, 2010). Our research findings reveal that family support, social support, and community programs play a very important role in healing members of the community. How can we empower communities and families to be a healthy support system? Who is going to establish a law to empower the community in its vital role?

The other important question is: Why isn’t there a Mental Health Care Act? Why are mental health practitioners the only responsible party in this issue that involves multiple systems? We invite you to see this as a collective issue—one that involves all of us, starting with our government and trickling down to every single citizen. When governments don’t get their way, they strike back. How is that different from what the school shooter in Newtown, Connecticut, did? We are in the midst of two wars (Iraq and Afghanistan) and on the verge of another two that are being quietly plotted (Syria and Iran). Change must come from our leaders, our government, the NRA, the school systems, communities at large, as well as individual families. We can all benefit from embracing a nurturing role of promoting understanding without judgment, empathy without ridicule, and rehabilitation rather than stigmatization of those with mental health issues—we can work together on prevention, preparation, and education of the general public.

The Sandy Hook school shooter seemed isolated in his comfortable home: He had no relationship with his father, a less-than-meaningful one with his mother, unresolved trauma from his childhood school, and an apparent lack of a social network. It’s often said that it takes a village to raise a child, and we need to take this statement seriously.

The unhealthy association of mental illness with violence only adds to the already heavy burden of the stigma felt by individuals with mental health issues. We agree with Dr. Christopher Gordon (2013) that those with mental health challenges have often been the target of abuse, violence, and neglect. Let’s work together to cultivate a caring and compassionate attitude toward our mentally ill and to work with them instead of against them. If we are all part of a comprehensive approach to caring for our mentally ill, perhaps future tragedies can be averted. After all, it takes a village to raise a child, but it takes just one child to raze a village.

References

- Gordon, C. (January 29, 2013). Invitation to a dialogue: Forcing treatment. *The Opinion Pages, The New York Times*.
- Kalayjian, A., & Eugene, D. (2010). *Mass trauma & emotional healing around the globe: Rituals and practices for resilience and meaning-making*. New York, NY: ABC-CLIO.
- Kaplan, K. (January 15, 2013). Sweeping limits on guns become law in New York. *The New York Times*, p. A15.
- Mills, K. I. (January 17, 2013). *American Psychological Association applauds provision of White House plan to stem gun violence*. APA News Press Release.
- Roy, Y. (January 19, 2013). What New York State’s new gun law says. *Newsday*. Retrieved from <http://www.newsday.com/news/region-state/what-new-york-state-s-new-gun-law-says-1.4477221>
- Ritter, M., & Tanner, L. (January 15, 2013). Mental health experts worry New York gun laws may discourage proper treatment. *Huffington Post*. Retrieved from http://www.huffingtonpost.com/2013/01/15/mental-health-experts-new-york-gun-law_n_2480508.html
- The White House Office of the Press Secretary. (2013). *Now is the time: The President’s plan to protect our children and our communities by reducing gun violence*. Retrieved from http://www.whitehouse.gov/sites/default/files/docs/wh_now_is_the_time_full.pdf

For more than a decade, Ani Kalayjian, PhD, has been on a journey of healing through forgiveness and meaning. She received an Honorary Doctor of Science Degree from Long Island University and earned a Master’s and Doctor of Education degree from Teachers College, Columbia University. As a pioneering therapist, educator, director and author, she has devoted her life to bringing healing to those who have survived the devastation of disaster, whether man-made or natural. She has private psychotherapeutic practices in Manhattan and Cliffside Park, NJ, where she resides, and she is an adjunct Professor of Psychology at Fordham University.

Nira Shah has obtained MA and EdM degrees in Psychological Counseling from Columbia University and has striven to enhance her understanding of global mental health and trauma. She has been a research assistant for the NYU/Bellevue Program for Survivors of Torture, International Trauma Studies Program, and the Association for Trauma Outreach and Prevention. She currently works in sub-Saharan Africa as a field caseworker for the U.S. Refugee Admissions program.

Special gratitude to Leysa Cerswell and Seta Papazian for their research and editorial guidance.



1990

Getting Started



2000

Building Your Life



2010

Providing For Others



2020...

Your life now may be very different than it was ten years ago...

Has your financial planning changed to fit your current or future picture? A new or expanding business, mortgages, automobiles, a larger family... these can all contribute to a very different picture of your financial responsibilities today.

Group Term Life Insurance

Term Life Insurance can play an important role in your family's continued financial security should you die prematurely. Whether you need initial coverage or want to add to what you have, Trust Group Term Life Insurance¹ is affordable and has the features you will need to keep pace with changing family and financial responsibilities.

Call us at **1-877-637-9700** or visit **www.apait.org** for a no-obligation consultation.

Great Coverage at Affordable Premiums Including These Features:

- ▶ **Inflation Safeguard** — designed to prevent changes in the cost of living from eroding your death protection.²
- ▶ **Living Benefits** — allows early payment of death benefits if you become terminally ill.
- ▶ **Disability Waiver of Premium** — waives your premium payment if you become totally disabled.

¹ Available in amounts up to \$1,000,000. Coverage is individually medically underwritten. Policies issued by Liberty Life Assurance Company of Boston, a member of the Liberty Mutual Group. Plans have limitations and exclusions, and rates are based upon attained age at issue and increase in 5-year age brackets.

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



www.apait.org

(877) 637-9700

The Division of Trauma Psychology—Your Home in APA

The Division of Trauma Psychology adds a psychological voice to the interdisciplinary study of trauma, offering knowledge from science and practice with the goal of enhancing clinical care, research, and education of psychologists.

Why join Division 56?

Members: Join a community of professionals committed to scientific research, professional and public education, and the exchange of collegial support for professional activities related to psychological trauma.

Early Career Psychologist Members (ECP's): Gain access to extensive networking opportunities with colleagues in the trauma field. Other benefits include professional development training, social hours and mentoring sessions at our annual conferences, and opportunities to write for the Division 56 newsletter.

Student Members: Become part of a nationwide network of fellow students with professional interests in psychological trauma. Benefits include opportunities for networking with experts in the field and access to the Division 56 Student Listserv, a forum in which students can participate in academic conversations and events regarding cutting-edge work in trauma psychology.

Member Benefits

- Access to the latest developments in trauma psychology
- E-newsletters delivered directly to your in-box and include timely information on traumatic stress
- Member-only listserv provides ongoing communication with other members and breaking news of trauma-related developments in APA
- Opportunities to network with colleagues and potential collaborators through social hours and mentoring events
- Participation in the Division's annual meetings and voting privileges to elect representatives
- Eligibility to run for office, chair, and serve on Division committees and task forces
- Subscription to our journal, Psychological Trauma: Theory, Research, Practice, and Policy, at the member rate of \$22.00 per year
- 30% discounts on Haworth/Taylor & Francis journals in the field of trauma

Join Division 56 Now!

Membership Category	Rate	Journal
<input type="checkbox"/> APA Associate/Member/Fellow	\$45.00	included
<input type="checkbox"/> Professional Affiliate*	\$45.00	included
<input type="checkbox"/> Early Career Psychologist	\$35.00	included
<input type="checkbox"/> First Year APAGS	Free	\$22.00
<input type="checkbox"/> Student	\$10.00	\$22.00

Total: _____

Name _____

Address _____

APA Member Number _____

Phone _____

Email _____

Method of Payment

- Check Payable to Division 56
- Visa
- MasterCard
- American Express

Credit Card # _____ Exp. date _____

Signature _____

*Professional Affiliate Membership is offered to individuals who are not members of APA. Applicants in this category must submit a description of professional training in trauma psychology or a related field, a curriculum vitae, and the name of a current member willing to provide a brief statement of endorsement. These materials should be submitted to the current Membership Chair at APADiv56Membership@gmail.com.

TRAUMA PSYCHOLOGY NEWSLETTER

An Official Publication of Division 56 of the
American Psychological Association

EDITORIAL STAFF

FOUNDING EDITOR

Topher Collier, PsyD

EDITOR

Simon A. Rego, PsyD, ABPP, ACT
Montefiore Medical Center
111 East 210th Street
Bronx, NY 10467
srego@montefiore.org

ASSOCIATE EDITOR

Renu K. Aldrich, MA, MFTi
Center for Coping
renu@renualdrich.com

CONSULTING EDITOR

Ruth A. Blizard, PhD
Independent Practice
231 Main Street
Vestal, NY 13850
(607) 348-7578
info@ruthblizard.com

ADVISORY EDITORS

Book Reviews

Renu K. Aldrich, MA, MFTi
Center for Coping
renu@renualdrich.com

Early Career Psychologist

Tyson Bailey, PsyD
tdbaileypsych@gmail.com

Lesia M. Ruglass, PhD
ruglass.ceny@gmail.com

International Committee

Elizabeth Carll, PhD, Chair
drcarll@optonline.net

Legal Affairs & Forensic Issues

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

Trauma and Health

Kathleen Kendall-Tackett, PhD,
IBCLC
kkendallt@gmail.com

Voices from the Classroom

Christy Denckla, MA
christydenckla@mail.adelphi.edu

Sarah Elizabeth Cleary, M.Ed.
sarahlizcleary@gmail.com

Who's Who

Nina K. Kominiak, BS
University of Alaska Anchorage

EDITORIAL ASSISTANTS

Co-Chief Editorial Assistant

Valentina Stoycheva, MA
Adjunct Professor
Adelphi University

Co-Chief Editorial Assistant

Sherrie L. Wilcox, PhD, CHES
Research Assistant Professor
University of Southern California

Jennifer R. Abbott, MA, LPC,
CAC II

Fielding Graduate University

Lea M. Didion, PsyD

Clinical Psychologist
James A. Hayley Veterans Affairs

Jackie Hammelman, MA

Nova Southeastern University

Alaa Hijazi, PhD

Bay Pines VA Medical Center

Nina K. Kominiak, BS

University of Alaska Anchorage

Carla R. Rosinski, MA, LPC

Rosinski Therapy and
Consultation

Gina Stepp, MA

Managing Editor: Vision Media
Publisher: *Mom Psych*

Vincenzo G. Teran, MA

Boston University School of
Medicine
Center for Multicultural Training
in Psychology

Leanne Valentine, PhD

Psychologist and Program
Manager
Coatesville VAMC

Kerrie G. Wilkins, MA

Arizona State University

DESIGN/LAYOUT

Keith Cooke
APA Division Services Office

LOGO DESIGN

Janet Perr
www.janetperr.com



The **TRAUMA PSYCHOLOGY NEWSLETTER** is a membership publication of the Division of Trauma Psychology, Division 56, of the American Psychological Association and, currently, produced three times a year. The newsletter provides a forum for sharing news and advances in practice, policy, and research, as well as information about professional activities and opportunities, within the field of trauma psychology.

The **TRAUMA PSYCHOLOGY NEWSLETTER** is distributed to the complete membership of Division 56 and includes academics, clinicians, students, and affiliates who share a common interest in trauma psychology. Unless otherwise stated, opinions expressed by authors, contributors, and advertisers are their own and not necessarily those of APA, Division 56, the editorial staff, or any member of the editorial advisory board.

Editorial correspondence and submissions (< 3,000 words) are welcomed and appreciated. Please submit articles and references in APA style and send, via e-mail, as an attachment in Word format, to the Editor exactly as you wish it to appear. With their submissions, authors should also include a brief author statement, contact info, and photo at 300 dpi or at least 600 pixels wide by 900 pixels high.

PUBLICATION SCHEDULE AND SUBMISSION DEADLINES

<u>Authors' Submission Deadline</u>	<u>Issue</u>	<u>Publication Date</u>
February 1	Winter	March
June 1	Summer	July
October 1	Fall	November

ACCURACY OF CONTENT AND COPY INFORMATION

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

ADVERTISING POLICY, RATES, AND QUERIES

The appearance of advertisements and announcements in the **TRAUMA PSYCHOLOGY NEWSLETTER** is not an endorsement or approval of the products or services advertised. Division 56 reserves the right to reject, edit, omit, or cancel advertising for any reason. Advertising and announcements, as well as copy and artwork, must meet certain size specifications and be submitted in camera-ready form no later than the submission deadlines for the print issue desired.

<u>Ad Size</u>	<u>Rate*</u>
Inside Back Cover (full page)	\$700
Full page	\$500
Half page	\$300
Quarter page	\$200
Multiple Insertion Discounts	15% discount for multiple insertions, per publication year, of single ad that are committed and paid in full with initial submission.

*For display ads with color or photos, add \$50 each to cost per issue inserted.

Division 56 reserves the right to edit all copy and to reject or cancel advertisements and announcements based on legal, professional, ethical, and social concerns. Inquiries about advertising rates, guidelines, and/or submissions should be e-mailed directly to the Editor.

DIVISION 56 LOGO INFORMATION

Requests for permission to use the Division Logo and information should be obtained from the Editor, Simon Rego (srego@montefiore.org). Credit for logo design should be given to Janet Perr (www.janetperr.com) whenever the Division logo is used.

© 2013 Division 56 of the American Psychological Association. All rights reserved. Current and past issues of the **TRAUMA PSYCHOLOGY NEWSLETTER** are available as PDF files via the Division 56 website (www.apatraumadivision.org).