

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

A View Inside

Special Section: Trauma and Military Veterans

Advancing the Understanding of Trauma and PTSD in Veterans.....	5
Gender Differences in Deployment Stressors and PTSD Among U.S. Veterans. 7	
Meeting the Needs of Veterans Who Have Experienced Military Sexual Trauma	9
Trauma and PTSD in Older Veterans	11
PTSD and Substance Use in Veterans	13
Disseminating Evidence-Based PTSD Treatments for Veterans.....	16
Use of Telemental Health in the Provision of Evidence-Based PTSD Care for Veterans. 18	

Featured Articles

Transforming Trauma from Violence Into Healing: A Nation Responds.....	21
Assessment and Treatment of Complex PTSD.....	24

Legal Affairs

One Woman's Story of How the Legal Nightmare Begins	26
-----------------------------------------------------------	----

Early Career Psychologists

Identifying and Managing Burnout, Compassion Fatigue and Vicarious Traumatization.....	29
----------------------------------------------------------------------------------------	----

Poem

Vicarious Trauma.....	32
-----------------------	----

International Committee

Linh Phuong Luu, M.S., Recipient of the 2013 Student Travel Award	33
-------------------------------------------------------------------------	----

Student Spotlight

Graduate Training and Trauma: The Need for Treatment Flexibility and Creativity	34
---------------------------------------------------------------------------------------	----

Who's Who

Beverly Ann Dexter, Ph.D.	36
--------------------------------	----

Division News

Apply for Fellow Status.....	37
------------------------------	----

Book Reviews

.....	38
-------	----

Opinion

Integrating Emotional Trauma: Trauma Recovery Is an Oxymoron	40
Hurricane Disaster: I Just Want My Life Back	40

NEWSLETTER

Presidential Voice

Constance Dalenberg, PhD

I write now in the space between the two major conferences that will take place during my Presidential year. The first, which occurred a few weeks ago in New Haven, Connecticut, was the Yale Trauma Conference that we sponsored, titled, "Advancing the Science of Education, Training and Practice in Trauma." Our leaders there were Joan Cook and Elana Newman. They shepherded about 50 of us through the development of a consensual list of the topics that should be covered in trauma training. You will hear more about this at the August convention in Hawaii.



Constance Dalenberg, PhD

I actually adore these meetings, especially when I'm not in charge. These are the people I most love to talk to and learn from. (Learning that apparently left out the lesson about not ending sentences with prepositions.)

Getting agreement from a set of 50 fairly high-powered professionals about exactly what should be learned, as well as how to phrase the sentences that outline this content, is an Olympian challenge.

That said, I have rarely come away from a meeting with greater respect for the leaders of an endeavor. Watching Elana and Joan gently corral us into obeying the rules of a given activity, answer questions for the thirtieth time in the same patient and involved manner, and take further editing suggestions to a sentence that had been through multiple committees and multiple editors, was a lesson in good leadership that I hope to have internalized. I'm proud of our decision to sponsor this event, since the outcome is important, and I'm proud of our achievement, but mostly I'm proud that you allow me to be part of this community.

continued on p. 3

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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: Contact Keith Cooke at kcooke@apa.org.

Presidential Voice

continued from p. 1

Conference Programming

We are now at the point where we should be spreading the word about the convention in Hawaii, so that people can make their travel plans. Make it a vacation too, folks. Tell your colleagues that the official convention programming is spread over 5 days and lasts only from 8 am to 2 pm, leaving time for surfing. (I took one lesson when the little APA invited me to Hawaii to speak, and I figure I need about 30 more to get to basic competence.) Among the MANY upcoming attractions are the following:

John Briere will be updating us on mindfulness and the treatment of trauma. Listening to John speak is one of my great pleasures. From him, and from Phil Zimbardo, who is also speaking, one hopes to get not only good content but also some subliminal training in the magic of really compelling scientific talks.

Phil Zimbardo has been a hero of mine for a long time, and has agreed to team up with one of his Hawaiian colleagues to talk about time perspective and trauma treatment.

George Bonanno will be offering us a seminar on regulatory flexibility, combining some of the tightest and most interesting designs with compelling theory that is important to our everyday clinical work with dysregulated clients.

Jill Stoddard and I will be speaking about Acceptance Commitment Therapy. Jill has an upcoming text on new metaphors for ACT, and I will be presenting new data on client perspectives on working through some of the ACT principles.

In the year 2012, the US suffered a high number of natural disasters, including Hurricane Sandy, a record-breaking heat wave in the Midwest, and some of the worst firestorms in the history of the West Coast. In response, Daniel Dodgen, Lisa Brown and Patricia Watson will be doing a training on “5 things every psychologist should know about disasters.”

Keeping up with the electronic age, we have an app workshop for trauma psychologists. These include: (a) games that support psychological skills, such as increasing positive thinking, (b) stress reduction, mindfulness, or stress monitoring applications, (c) apps that promote specific cognitive skills, such as inhibition or memory, (d) apps that promote positive cognitive appraisals. Joe Rusek is presenting the data for the PTSD Coach app, and Simon Rego will be presenting a variety of applications on distress tolerance and affect regulation that are valuable to the trauma psychologist.

The cognitive therapies are well-represented by Terry Keane, who is presenting data on combat populations, and Lori Zoellner and Michael De Arellano, who are presenting data on innovations in cognitive trauma treatment for adult and child civilian samples.

The forensic psychologists among you will be glad to hear that Division 41 has a trauma focus this year, so you will have the choice to learn about trauma evaluation of victims and perpetrators from a variety of perspectives and at beginning, intermediate and advanced levels.

Suite Programming

We are trying a new format for the suite programming. Please drop by for some of our activities. In addition to the opportunities for socializing that we will host there, we have three opportunities that are unusual and FREE to 56 members. The suite programming doesn't conflict with the main program. It occurs from 2 to 6 pm each day.

Research mentoring: Do you have a paper you want to publish or a design or statistical problem on your trauma paper or trauma-related dissertation? We have reserved a half day in the suite for mentoring. If you email the nature of your issue, we can pair you with a major researcher in trauma (like Terry Keane), an editor or associate editor of a trauma journal (like Steve Gold) or a methods/statistics maven who has chaired a truckload of dissertations (like myself). Mentoring sessions will last half an hour, and need to be booked prior to the convention. The address to make your request is div56.suite@gmail.com. For those outside of Division 56, there is a \$35 charge for this meeting. These meetings will take place on Saturday, August 3.

Biofeedback training: Incorporating heart rate variability into your practice is now practical financially, since the hardware has come down dramatically in price. We are holding a 2-hour training to teach you to use several of the low-cost devices, as well as teach you the basics of HRV biofeedback theory. This is hands-on, so you can experiment with the devices and feel comfortable with them, as well as ask the specific questions you need to ask. This will take place from 2 to 4 pm on Thursday, August 1. It costs \$50 to attend, but is free to 56 members. Reserve your slot with Jan Estrellado, suite coordinator at div56.suite@gmail.com. First come, first serve, up to 10 attendees.

Setting up a forensic practice: Laura Brown, Lisa Rocchio and Steve Gold will be holding a 2-hour training on the practicalities of setting up a forensic practice. You will not only learn some do's and don'ts, but will also come away with a CD packed with sample consent forms, sample guidelines, and other valuable resources. This training costs \$35 but is free to Division 56 members. Again, we will accept the first

12 reservations. Email Jan Estrellado at div56.suite@gmail.com.

Division 56 continues to create and define itself. The Trauma Assessment Guidelines, a tightly written document by a Division 56 committee headed by Judith Armstrong, will be helpful to a new generation of psychologists. In process now are the treatment guidelines for Complex Trauma, under the able guidance of Christine Courtois (who is as always a powerhouse writer and thinker). We also have in process, out in the new few months, a guideline for graduate students and academics who are attempting to negotiate with their local IRB's. We discuss research that you might present to argue for the relatively benign effect of noncoercively asking about trauma history, and the unintended harm

that might be done by IRB's who force researchers to exaggerate the potential harms of disclosure. This document was composed by the Executive Committee of Division 56 and I offer my continued gratitude to all of them.

My hope for Division 56 is that we continue to create documents and experiences such as those above that will contribute to the education of the new generation of trauma psychologists and that will provide resources for those in pain. Please contact me if you would like to volunteer in one of our projects. We need you, and you can find in us a professional home. Email me with your ideas and requests at cdalenberg2@alliant.edu.

Fall 2013 TPN: Call for Articles and Special Note

Trauma Psychology News is now accepting submissions for the Fall 2013 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 September 15, 2013. 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)

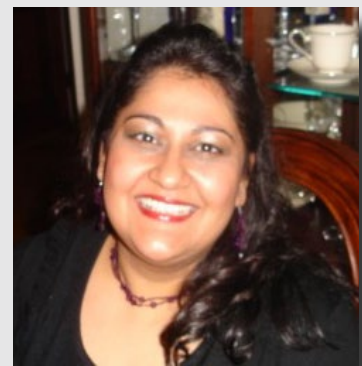
with your submission. Article submissions or requests for full editorial guidelines should be sent to Simon A. Rego, PsyD, Editor (sreg@montefiore.org) and Renu Aldrich, MFTi, Associate Editor (renu@renualdrich.com).



Simon A. Rego, PsyD

Special note: We are pleased to announce that the Fall 2013 issue will feature a special section that takes a retrospective look at the history and development of trauma treatments. It will be guest edited by Drs. Edna Foa, David Yusko, and Carmen McLean. Dr. Foa 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 has devoted her academic career

to studying the psychopathology and treatment of anxiety disorders, and is currently one of the world's leading experts on the treatment of Posttraumatic Stress Disorder. Dr. Yusko is Clinical Director at the Center for the Treatment and Study of Anxiety and Dr. McLean is Assistant Professor of Clinical Psychology in Psychiatry at the Center for the Treatment and Study of Anxiety. The section will include articles from top experts that discuss the history and development of (1) conceptualization of PTSD and its treatment; (2) cognitive approaches to treating PTSD; (3) exposure therapy for PTSD; and (4) efforts to disseminate EBTs for PTSD.



Renu Aldrich, MFTi

Advancing the Understanding of Trauma and Posttraumatic Stress Disorder in Veterans

Paula P. Schnurr, Ph.D.

National Center for PTSD and Geisel School of Medicine at Dartmouth

Sonja V. Batten, Ph.D.

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This issue of the *Trauma Psychology Newsletter* focuses on military veterans, a population that has played a significant role in furthering the understanding of not only combat trauma but trauma in general. Clinicians and researchers working with returning Vietnam veterans contributed to the formalization of the PTSD diagnostic criteria in 1980. Some of the earliest studies on PTSD—on treatment, instrument development, epidemiology, and neurobiology, for example—were based on veteran samples. Those working with veterans have continued to advance the science and practice of trauma psychology around the world. We are fortunate that a number of these experts contributed to this special issue.

In 2012 there were over 22 million American veterans, about 10% of whom are women. Veterans of the Vietnam War make up the largest single cohort of veterans, but the demographics of the population have been changing rapidly in the last decade due to mortality in World War II and Korean War veterans and the influx

of recent veterans of the wars in Iraq and Afghanistan. This newest cohort includes more women than in prior eras, and women are the fastest growing demographic in the veteran population.

The article by Vogt and Street describes the changing roles of women in the military along with resulting changes in trauma exposure. More women are directly exposed to combat now and even more will be with the recent lifting of the combat ban, but military sexual trauma—MST—remains a significant source of traumatic exposure. The article by King offers more details, noting that military sexual trauma also occurs in men despite its higher prevalence in women. Both articles also describe how combat exposure and MST can lead to PTSD and other disorders. The finding that male and female veterans seem to have comparable responses to combat and other military stressors stands in stark contrast to findings in non-veteran samples, where the likelihood of PTSD is much higher in women than in men. The reasons for the difference, which have fueled much debate and further research, support the idea that ability and training—not gender—are most important in response to challenging military situations.

Another component of the changing demographic characteristics of the veteran population is the aging of the Vietnam cohort. Many Vietnam veterans are now beyond age 65. Thorp and Cook discuss unique factors

Special Section on Trauma and Military Veterans

Guest Editors: Paula P. Schnurr, Ph.D. and Sonja V. Batten, Ph.D.

Advancing the Understanding of Trauma and Posttraumatic Stress Disorder in Veterans	5
<i>Paula P. Schnurr, Ph.D., and Sonja V. Batten, Ph.D.</i>	
Gender Differences in Deployment Stressors and Posttraumatic Stress Disorder Among U.S. Veterans.....	7
<i>Dawne Vogt, Ph.D., and Amy E. Street, Ph.D.</i>	
Meeting the Needs of Veterans Who Have Experienced Military Sexual Trauma.....	9
<i>Matthew W. King, Ph. D.</i>	
Trauma and PTSD in Older Veterans.....	11
<i>Steven R. Thorp, Ph.D., ABPP, and Joan M. Cook, Ph.D.</i>	
Posttraumatic Stress Disorder and Substance Use in Veterans.....	13
<i>Jessica L. Hamblen, Ph.D., and Daniel Kivlahan, Ph.D.</i>	
Disseminating Evidence-Based PTSD Treatments for Veterans	16
<i>Katheen M. Chard, Ph.D., Afsoon Eftekhari, Ph.D., and Bradley E. Karlin, Ph.D.</i>	
Use of Telemental Health in the Provision of Evidence-Based PTSD Care for Veterans	18
<i>Tracey L. Smith, Ph.D., Leslie Morland, Psy.D., and Peter W. Tuerk, Ph.D.</i>	

in working with older trauma survivors, noting that older adults in general have not been included in much of the trauma research that has been conducted over the past 30 years. As the experiences of Vietnam veterans greatly influenced the development of the original construct of PTSD, their experiences as an aging population are now likely to advance the understanding of trauma in older adults.

PTSD often co-occurs with a range of mental and physical health problems; comorbidities of depression, anxiety, anger, pain, and traumatic brain injury are frequently seen in clinical practice where it is often the exception to see a patient who meets criteria for PTSD alone. Substance use is a common and complicated comorbidity because it can lead to a range of other psychiatric and functional problems along with adverse effects on physical health. The article by Hamblen and Kivlahan illustrates why it is so important for clinicians to assess and treat comorbid substance use disorders in veterans who have trauma histories.

The last two articles focus more directly on treatment. There is a great deal of ongoing research on this topic: new medications, new ways of delivering existing therapies, third-wave cognitive-behavioral therapies like Acceptance and Commitment Therapy, complementary and alternative medicine, and brief treatments for primary care settings to name a few. The PTSD Practice Guideline issued by the Department of Veterans Affairs (VA) and Department of Defense (2010) illustrates the variety of treatments that are effective for PTSD. However, not enough patients receive these treatments. One barrier to implementation is a lack of knowledge among providers. Chard, Eftekhari, and Karlin describe a national training initiative in VA to disseminate two evidence-based psychotherapies for PTSD. But even if therapists are trained in evidence-based treatment, logistical barriers may prevent patients from accessing these treatments. Smith, Morland, and Tuerk describe how video, Web, and smartphone technologies designed to break through access barriers can deliver the care patients need in formats they want. The authors also discuss how concerns about patient safety—another potential barrier—have been overcome as data have emerged to show that telemental health is both safe and effective.

We have highlighted some of the most important topics related to understanding and treating trauma and its consequences in veterans. An important topic that we did not include is resilience, and its counterpart, risk. Exciting findings are emerging from various longitudinal studies following military personnel before, during, and after deployment—something that is usually impossible, or at least very difficult, when studying civilian trauma. These studies will contribute significant new knowledge about risk and resilience that can enhance understanding and inform further screening, prevention, and treatment efforts in all trauma populations.

Anyone who reads the historical medical literature published following major military conflicts is likely to be struck by the similarity in clinical descriptions of readjustment problems in veterans of all eras. But everything old isn't just new again. Over time, we have made meaningful gains in understanding and treating the impact of war service. Most recently our focus has come to include recognition of the importance of moving from a strictly clinical approach to one that includes a public health perspective. Two national online public awareness and outreach campaigns launched by VA, Make the Connection (<http://www.maketheconnection.net/>) and About Face (<http://www.ptsd.va.gov/apps/AboutFace/>), exemplify the shift in perspective as well as the use of the technology to expand reach. The message offered to veterans is simple: *You are not alone and effective treatment is available.* Although designed to improve the lives of veterans, the power of communicating these simple truths at a societal level is something that can raise awareness about trauma in all populations.



Paula P. Schnurr, Ph.D.



Sonja V. Batten, Ph.D.

Reference

Department of Veterans Affairs/Department of Defense. (2010). *Clinical practice guideline for the management of post-traumatic stress* (Version 2.0.). Washington, DC: Authors.

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Gender Differences in Deployment Stressors and Posttraumatic Stress Disorder Among U.S. Veterans

Dawne Vogt, Ph.D., and Amy E. Street, Ph.D. National Center for PTSD, VA Boston Healthcare System, and Boston University School of Medicine

Evolution of Women's Role in the War Zone

While women have long served with distinction in the U.S. military forces, both the number of women serving, as well as their roles in the war zone have expanded substantially over the years (Street, Vogt, & Dutra, 2009). About 7,000 women were deployed to Vietnam, where they primarily served as nurses or in clerical positions. Approximately 40,000 women were deployed in support of the 1990-1991 Gulf War, where they served in a much broader range of positions that included combat support roles. During the most recent conflicts in Afghanistan (Operation Enduring Freedom; OEF) and Iraq (Operation Iraqi Freedom; OIF and Operation New Dawn; OND) over 200,000 women have been deployed, with many women working side-by-side with male service members in roles that place both groups at risk for combat exposure. In fact, recent findings indicate that most female



Dawne Vogt, Ph.D.



Amy E. Street, Ph.D.

service members have experienced at least some combat in these recent wars. For example, in one study, 77% of women deployed in support of OEF/OIF, compared to 85% of men, reported exposure to at least one combat experience (Vogt, Vaughn, et al., 2011). Another study based on this cohort found that women were almost as likely as men to report experiencing at least one combat event, although gender differences were larger when analyses were restricted to personnel with more substantial levels of combat exposure (Street, Gradus, Giasson, Vogt & Resick, in press).

Gender Differences in Combat Contexts

Despite the increasing similarity in women's and men's combat exposure in the war zone, the context within which women and men experience combat may be quite different. Although both genders are exposed to a range of stressors during deployment, women report more frequent exposure to some stressors. At the most basic level, women report unique health-related stressors, including challenges with maintaining menstrual hygiene due to limited access to shower and bathroom facilities, as well as difficulties accessing gynecological care in the war zone (Trego, 2012). Women are also at risk for a range of interpersonal stressors in the war zone, including experiences of sexual harassment and

Note: This research was supported, in part, by a Department of Veterans Affairs Health Sciences Research and Development Service grant (DHI 09-086; PI: Dawne Vogt, PhD).

sexual assault, as well as exposure to gender-based harassment. Survey data reveal that women, across cohorts, are more likely than men to report experiences of sexually based and other forms of harassment during deployment (Vogt, Pless, King, & King, 2005; Street et al., in press). Not only do these experiences have direct implications for the post-deployment mental health of veterans, but they may also compound the negative impact of other stressors experienced during deployment.

Female veterans are also less likely than male veterans to report social support from military peers and superiors during deployment, an important resource that may reduce the negative psychological effects of combat exposure and other deployment stressors (Street et al., in press). This lack of support may be especially problematic given that social support has been found to be more protective against post-deployment PTSD for women than men (e.g., King, King, Foy, Keane, & Fairbank, 1999; Vogt, Smith, et al., 2011). Finally, because women are more likely than men to serve as primary caregivers for both children and extended family members, stress associated with family separations may also be more salient for female, compared to male, service members. This is an important area for additional research, as few studies have explored gender differences in family-related stressors and their impact on veterans' post-deployment adjustment.

Gender Differences in Posttraumatic Stress Disorder Following Deployment

Women in the general population are two to three times more likely than men to develop PTSD (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012). However, gender differences in PTSD in veteran samples do not always follow this pattern. This lack of consistency across cohorts may be due, at least in part, to women's evolving roles during combat deployments. Results are reversed in the Vietnam cohort, with male veterans being at approximately twice the risk of a PTSD diagnosis compared to their female counterparts (Kulka et al., 1990). In contrast, in the Gulf War cohort, gender differences parallel those found in the general population, with female veterans being at double or triple the risk of their male counterparts (Wolfe, Erickson, Sharkansky, King, & King, 1999). Although data are still emerging for the OEF/OIF/OND cohort, existing studies have identified limited evidence for gender differences in PTSD, with men and women being at roughly comparable risk (Street et al., 2009). Studies that have examined gender differences in the impact of particular deployment experiences on PTSD have also revealed few differences in this cohort. For example, a recent investigation of the impact of several different combat stressors on PTSD symptom severity showed similar results for both women and men deployed in support of OEF/OIF (Vogt, Vaughn, et al., 2011). Building on this work, Street and colleagues (in

press) found that the strength of associations between both combat stress and PTSD and harassment stress and PTSD were quite similar for female and male OEF/OIF veterans. Collectively, these findings suggest that although women and men experience somewhat different stressors during deployment, the impact of these stressors on their post-deployment mental health may be more similar than different.

These findings certainly do not preclude the possibility that gender differences in PTSD may emerge under certain circumstances. For example, one study found that women who experienced a combat-related injury during OEF/OIF were more likely than their male counterparts to report PTSD symptoms (Maguen, Luxton, Skopp, & Madden, 2012). Moreover, there is some evidence that other stressors, including both lack of social support and family-related stressors, may have differential implications for the post-deployment mental health of veterans (Vogt, Smith, et al., 2011).

These findings underscore the importance of further research on this topic, which is more critical now than ever, when women have been exposed to combat trauma at much higher rates than in the past. The most important implication of research on gender differences in deployment experiences and the gender-specific risk for PTSD will be to proactively address the treatment needs of both female and male veterans. Indeed, the VA offers a wide range of mental health services to meet women veterans' unique needs (e.g., psychological assessment and evaluation, outpatient individual and group psychotherapy, acute inpatient care and residential-based psychosocial rehabilitation), including specialty services that target PTSD.

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Meeting the Needs of Veterans Who Have Experienced Military Sexual Trauma

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Incidents of sexual assault in the military first came to widespread public attention after the Navy's 1991 Tailhook scandal. Soon after, growing awareness of the potentially damaging impact of military sexual assault helped motivate the first federal law authorizing the Department of Veterans Affairs (VA) to treat conditions resulting from sexual assault and severe sexual harassment during military service (Veterans Health Care Act of 1992). In the VA context, these two types of experiences are identified collectively as "military sexual trauma" (MST). VA-led efforts over the last two decades have significantly expanded

knowledge on treating the associated health effects.



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Prevalence

VA administrative data provide one source of information for estimating how many veterans have experienced MST. Recognizing that sexual trauma survivors often do not disclose their experiences unless asked directly, VA instituted a universal screening program in 2002 for all veterans in its care. Early program data revealed that 21.5% of women and 1.1% of men reported MST when screened by their provider (Kimerling, Gima, Smith, Street, & Frayne, 2007). Yearly prevalence estimates have remained consistent, including among VA-user veterans who served in Iraq and Afghanistan (15.1% of women and 0.7% of men; Kimerling et al., 2010). However, estimates based on VA users—a

treatment-seeking population—may not generalize to all veterans. Unfortunately, epidemiological studies outside of VA are sparse; although in one national survey of former reservists, sexual harassment during service was

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reported by 60.0% of women and 27.2% of men and sexual assault by 13.1% of women and 1.6% of men (Street, Stafford, Mahan, & Hendricks, 2008). More research is needed to establish reliable estimates for veteran populations who are not accessing VA healthcare, particularly across different eras of service.

What is clear, however, is that MST is a concern not only for women veterans but for men as well. Despite the gender difference in prevalence, when given the comparatively greater number of men in military service, the absolute numbers of female and male MST survivors in the veteran population are of similar orders of magnitude. For example, in 2012, VA data showed that among veterans seen for VA health care 72,497 women and 55,491 men reported experiencing MST (MST Support Team, 2013).

Impact

Like sexual assault more generally, MST is an interpersonal trauma, involving harm from another (often trusted) person. The military context can create unique dynamics, however. Aspects of military culture, such as an emphasis on strength, self-sufficiency, and ideals related to relying on “Servicemembers in arms” may make victimization particularly difficult to comprehend and can complicate recovery. In certain military settings (e.g., deployments), survivors are sometimes forced to continue working and living near their perpetrator. This chronic stress and sense of being trapped can be psychologically damaging and also increases risk for revictimization.

Not every MST survivor will have long-term difficulties following the experience, but for some, the consequences of trauma can become chronic. There is an unequivocal association between MST and increased risk or severity of posttraumatic stress disorder (PTSD) and a range of other psychological disorders. Research has found the association in both women and men, across study designs that include medical records and interviews of VA patients, post-deployment screenings of active duty personnel, and population-based surveys of veteran cohorts (Hyun, Pavao, & Kimerling, 2009). Among experiences associated with PTSD, MST is typically found to be an equal or stronger predictor of PTSD than other military-related stressors (such as combat) or sexual assault during childhood or civilian life (Hyun et al., 2009; Suris & Lind, 2008). One study found that among VA patients with PTSD, MST survivors had a comparatively greater number of comorbid psychiatric diagnoses, particularly depression, anxiety, and eating disorders among women and substance use disorders among men (Maguen et al., 2012).

It is not uncommon for MST survivors to experience impaired physical health as well. Survey and medi-

cal record studies have found that a history of military sexual assault and harassment is linked with chronic pain and fatigue, obesity, migraines, vision and hearing difficulties, chronic cardiac, pulmonary, gastrointestinal and gynecological problems, and AIDS (Suris & Lind, 2008). Some research suggests that chronic posttraumatic stress symptomatology partially explains this increased prevalence of medical symptoms (Smith et al., 2011).

Care for Veterans

VA has a range of initiatives to help veterans recover from the aftereffects of MST. All care for MST-related health conditions is provided free of charge, without regard to service-connected disability. Every VA medical center offers outpatient services, including evidence-based psychotherapies with demonstrated effectiveness in treating posttraumatic stress. These include Prolonged Exposure and Cognitive Processing Therapy, both originally developed for survivors of civilian rape and child sexual abuse. Randomized clinical trials have shown these treatments to be more effective than control treatments at reducing PTSD symptoms among veterans with MST experiences (Schnurr et al., 2007; Suris, Link-Malcolm, Chard, Ahn, & North, 2013). VA offers mental health specialty services, including services for substance use disorders and homelessness, as well as inpatient or residential rehabilitation programs when more intensive treatment is needed. The universal screening program has been shown to facilitate efficient referral to mental health services (Kimerling, Street, Gima, & Smith, 2008). Given that survivors present with a range of treatment needs and seek care in a variety of clinical settings, training on MST is mandatory for every VA mental health and primary care provider. Every facility has a designated MST Coordinator to act as point of contact and advocate for MST survivors, and a national-level MST Support Team coordinates VA-wide monitoring, training, and outreach initiatives. Utilization of MST-related mental health care in VA continues to increase annually, an indication that outreach to this population has met with success.

Conclusion

Sexual trauma during military service has a serious impact on the health of America’s veteran population, necessitating a serious response from health care institutions. Despite two decades of progress, several important questions remain unanswered. Treatment effectiveness research involving MST survivors has focused almost exclusively on PTSD, but survivors are at risk for a wide array of negative health consequences. As such, research is needed on the effectiveness of mental health treatment for conditions other than PTSD among MST survivors. Secondly, although men constitute nearly half the MST survivors in VA, they gener-

ally use MST-related mental health services at lower rates than women (MST Support Team, 2013) and are often not included in research samples. Designing studies that facilitate gender comparisons in the experience and treatment of MST could elucidate factors contributing to the treatment use disparity and inform efforts to lower barriers to care. These are our challenges for the years ahead as we continue much needed efforts to help veterans recover from the aftereffects of sexual trauma endured while serving our country.

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Trauma and PTSD in Older Veterans

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Much of what is known about psychological trauma, including PTSD, comes from studies of younger adults. However, many of the military Veterans who served in past wars (including World War II, the Korean War, and the Vietnam War) are now aged 65 or older. There is a concern that PTSD may be under-recognized and under-treated in this population. Thus, it is important to examine the prevalence and course of PTSD and to consider assessment and treatment issues among older Veterans.

Data from a nationally representative study of U.S. Veterans indicate that the current PTSD prevalence is 3.5% in those aged 60 or older (Pietrzak & Cook, in press). Overall prevalence of full PTSD

appears to be lower in older Veterans compared to younger Veterans (Frueh et al., 2004). However, these estimates may not reflect the lifetime impact of trauma in the total population. There is a suspected survivor bias in studies of older adults with PTSD, such that only living and relatively healthy individuals are included in later-life prevalence estimates. Moreover, subthreshold PTSD (wherein all but one or two criteria are present) is a prevalent and clinically significant problem in this population. For example, a study by Bramsen & van der Ploeg (1999) found that the prevalence of current PTSD was 7.1% among World War II Veterans (mean age 67.6 years), but that an additional 20% met two of the three core PTSD criteria. In a sample of male Veterans of World War II and the Korean War (mean age 72.4 years, range 59-92), the prevalence of full current PTSD was 0.5%, but an additional 2.2% met all but 1 or 2 of the criteria (Schnurr, Spiro, Vielhauer, Findler, & Hamblen, 2002). Thus, although the prevalence of full PTSD appears to be relatively low (and lower than in younger Veterans), an additional percentage of older Veterans may have clinically important PTSD symptoms.

Much of what we know about the course of PTSD in older Veterans is from studies of former prisoners of war (POWs). In one retrospective investigation of POWs, one-fifth reported continuous PTSD symptoms following their release from captivity, an equal number reported no symptoms, and the majority reported symptoms that waxed and waned over time (Zeiss & Dickman, 1989). Longitudinal data from POWs suggest a U-shaped pattern of PTSD—severe PTSD immediately after captivity, followed by a gradual decline and re-emergence in later life (Port, Engdahl, & Frazier, 2001). Many older combat Veterans report a worsening of symptoms after exposure to media coverage of the wars in Iraq and Afghanistan. Exacerbation of PTSD symptoms in older adulthood may also occur due to diminished activity levels, interpersonal loss, cognitive and physical health problems, and retirement (Thorp, Sones, & Cook, 2011), but new onset of PTSD from past traumatic events is not common.

When assessing PTSD in older Veterans, a number of important issues should be considered (see Thorp et al., 2011). Older adults may fail to recognize their symptoms and minimize them due to stigma about mental health issues. Diagnostic assessment in this population can also be complicated by medical conditions and medications. For example, the milestones used to gauge “foreshortened future” in the DSM-IV system (e.g., marriage, birth of children) may not apply as well to older adults. Although several PTSD measures have been validated in older Veterans, lower cutoff scores are generally recommended. There is some evidence that older Veterans express fewer symptoms of hyperarousal, avoidance, and numbing compared with younger Veterans (Frueh et al., 2004). Providers should systematically ask older Veterans whether they have experienced traumatic events and provide education about PTSD when indicated.

A handful of studies have investigated treatment of older adults with PTSD, but most are single case designs. Although exposure therapies have well-established efficacy with younger adults, some authors have suggested that intensive exposure is contraindicated for older individuals. However, the two largest psychotherapy studies for older Veterans with PTSD demonstrated that they can benefit from exposure therapy (see Thorp, Stein, Jeste, Patterson, & Loebach,

2012). There have been few drug studies focused on older Veterans, but one study found a reduction in PTSD symptoms after treatment with the drug quetiapine (Hamner, Deitsch, Brodrick, Ulmer, & Lorberbaum, 2003).

PTSD is associated with poorer cognitive functioning in older adults, and much of this research has focused on Veterans (Shuitevoerder et al., in press). In one study, older Veterans with PTSD were more than twice as likely to develop dementia compared to those without PTSD (Yaffe et al., 2010). Conversely, there are indications that dementia exacerbates PTSD in Veterans (Johnston, 2000). Since many psychotherapies are learning-based, it is possible that individuals with cognitive impairments may not respond to these treatments as well as others. However, there is a case report that indicated that exposure therapy was helpful for an older male Veteran with dementia, perhaps due to a focus on more behavioral and affective rather than cognitive tasks in this type of therapy (Duax, Waldron-Perrine, Rauch, & Adams, 2013). Cognitive training may also improve cognitive functioning to aid treatment (see Shuitevoerder et al., in press).

There are many promising avenues for research relevant to older Veterans with PTSD. Future studies would benefit from the inclusion of older Veterans and analyses of age differences. These analyses could help to disentangle the effects of age from the effects of the chronicity of PTSD. There is a particular need for longitudinal studies that follow Veterans with PTSD into older adulthood. Many Veterans who have experienced traumatic events do not develop PTSD, and investigations of resilience and posttraumatic

growth among older Veterans are warranted. It is also important to consider how stigma may influence the assessment and treatment of PTSD in older Veterans, and to explore other potential barriers to care.

PTSD should not remain a hidden variable in the lives of older Veterans. We are beginning to understand more about the prevalence and course of PTSD during the lifespan. Valid assessments for older adults with PTSD are available, and it is important for clinicians to assess for full and subthreshold PTSD as well as



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cognitive functioning in older Veterans. Fortunately, there are efficacious treatments that can be considered for this population.

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Posttraumatic Stress Disorder and Substance Use in Veterans

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The comorbidity of posttraumatic stress disorder (PTSD) and substance use disorders (SUD) presents a serious challenge to many clinicians. Providers report that these patients are more difficult to treat than those with either disorder alone, leaving many clinicians unsure which treatment approach is best. It has been common practice to treat the SUD first out of concern that focusing on the trauma will cause relapse (Back, Waldrop, &

Brandy, 2009). However, there is growing evidence that addressing both conditions concurrently is the most effective approach.

Prevalence

Over three-quarters of men and women with lifetime PTSD have another comorbid lifetime diagnosis (Kessler, Sonnega, Bromet, Huges, & Nelson, 1995). Often PTSD co-occurs with substance use. According to one national epidemiologic study, 46.4% of individuals with lifetime PTSD also met criteria for SUD (Pietrzak, Goldstein, Southwick, & Grant, 2011). In another national epidemiologic study, 27.9% of women and 51.9% of men with lifetime PTSD also had SUD (Kessler et al., 1995). Women with PTSD were 2.48 times more likely to meet criteria for alcohol abuse or dependence and

4.46 times more likely to meet criteria for drug abuse or dependence than women without PTSD. Men were 2.06 and 2.97 times more likely, respectively (Kessler et al., 1995).

There are few comparable population prevalence estimates among veterans. The National Vietnam Veterans Readjustment Study, conducted in the 1980s, found 74% of Vietnam theater veterans with PTSD had comorbid SUD (Kulka et al., 1990). Whether these findings generalize to other cohorts is unknown. One might expect that the prevalence of comorbid SUD would be higher in veterans than civilians because some studies suggest that veterans have poorer mental health (e.g., Hoerster et al., 2012; Lehavot, Hoerster, Nelson, Jakupcak, & Simpson, 2012).

Studies of treatment-seeking samples have tended to report on current rather than lifetime diagnoses and to focus on the prevalence of PTSD in patients seeking SUD treatment. These studies show that up to half of patients seeking treatment for substance use meet criteria for current PTSD (Berenz & Coffey, 2012), but the estimates are highly variable—possibly due to heterogeneity in sample characteristics. Much information about treatment-seeking veterans comes from Department of Veterans Affairs (VA) administrative data. During the past 10 years, the number of veterans with comorbid SUD and PTSD in VA care has increased more than three-fold; in 2012, the prevalence of PTSD among veterans receiving specialized SUD care was 32% (J. Trafton, personal communication, April 9, 2013). Thus, a substantial majority of veterans with PTSD have met criteria for comorbid substance use at some point and about a third in SUD specialty care are diagnosed with both disorders.

Treatments for Co-occurring PTSD and SUD

Several models have been proposed to account for the association between PTSD and SUD. Data most strongly support the model in which PTSD precedes the substance use and substances are used as a symptom management strategy. Then, withdrawal symptoms may trigger and exacerbate PTSD symptoms, initiating a cycle that precipitates poorer addiction outcomes (Berenz &

Coffey, 2012). Therefore, it is critical that treatments address the PTSD as well as the SUD.

The revised VA and Department of Defense (DoD) *Clinical Practice Guideline for the Management of PTSD* provides recommendations for the management of co-occurring PTSD and SUD (VA/DoD, 2010). The recommendation with the highest level of evidence is to offer smoking cessation treatment to patients with nicotine dependence. There was insufficient evidence to support a preferred sequencing of treatments for PTSD or SUD. As a general rule, evidence-based treatments for patients with both PTSD and SUD should be delivered concurrently with ongoing monitoring of response to treatment for both conditions.

Despite understandable enthusiasm for integrated treatments, several reviews have concluded that they may be no better than stand-alone treatments delivered concurrently (e.g., Berenz & Coffey, 2012). For example, Seeking Safety, an integrated non-trauma focused treatment, has been widely implemented in VA and elsewhere, with high acceptability to patients and providers. Although early studies found support for Seeking Safety, the most rigorous randomized controlled trials in civilians and veterans suggest that it is generally comparably effective to SUD treatment alone for reducing symptoms of PTSD and substance use (e.g., Boden et al., 2011; Hien et al., 2009).

A new Australian study shows that individuals with PTSD and SUD can tolerate and benefit from an exposure-based treatment (Mills et al., 2012). COPE is a treatment that includes Prolonged Exposure for PTSD and Motivational Enhancement Therapy and CBT for SUD. Civilian patients with PTSD and SUD randomized to COPE plus usual treatment had a greater reduction in PTSD than those in treatment as usual, but there were no group differences in substance use.

In the area of pharmacotherapy for co-occurring SUD and PTSD, several studies have found limited success with an SSRI in targeting comorbid Axis I symptoms that increase likelihood of use or relapse (Berenz & Coffey, 2012). Another small trial found reductions in alcohol craving and PTSD symptoms



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with disulfiram and naltrexone (Petrakis et al., 2006). Although acute, time-limited use of benzodiazepines alleviates alcohol withdrawal, the VA/DoD Guideline found no evidence that ongoing benzodiazepine treatment alleviates the core symptoms of PTSD.

To ensure that veterans can access optimal care, in 2008 the VA authorized funding for a substance use disorder specialist to augment each facility's specialty PTSD treatment services. These specialists work with PTSD specialty treatment providers to coordinate treatment planning and delivery of services. Their focus is supporting the efforts of the treatment team in addition to providing ongoing clinical care to some patients with the co-occurring disorders.

Conclusion

Clinicians working with veterans are likely to need to address comorbid PTSD and SUD. These patients may have complicated clinical presentations, poorer treatment prognoses, and can be a challenge to treat. Although integrated treatments are intuitively appealing and can be beneficial for some, there is insufficient evidence that they are consistently effective for both disorders. The VA/DoD PTSD guideline (2010) recommends providing evidence-based treatments for the individual disorders concurrently. At a very minimum, patients with comorbid PTSD and SUD do not need to wait for a substantial period of abstinence before addressing their PTSD. A growing number of studies demonstrate that these patients can tolerate trauma-focused treatment indicating that providers have a range of options to help improve the lives of patients with the co-occurring disorders.

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Disseminating Evidence-Based PTSD Treatments for Veterans

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Mental health providers deliver evidence-based psychological treatments for PTSD and other conditions infrequently, despite the well-documented effectiveness of and strong guideline recommendations for these treatments (Department of Veterans Affairs/Department of Defense, 2010; Goisman, Warshaw, & Keller, 1999; Rosen et al., 2004). In an effort to make these treatments widely available to veterans, the Veterans Health Administration (VHA) has implemented a national effort to disseminate evidence-based psychotherapies for PTSD and other mental health conditions throughout the Department of Veterans Affairs (VA) health care system.

In 2007, VHA launched two initiatives to promote the availability of Cognitive Processing Therapy (CPT; Resick & Schnicke, 1996) and Prolonged Exposure (PE; Foa, Hembree, & Rothbaum, 2007). Both CPT and PE have been shown to be effective in a number of randomized controlled trials and for multiple types of trauma, including sexual trauma and combat-related trauma (e.g., Chard, 2005; Foa et al., 2005; Monson et al., 2006; Resick, Nishith, Weaver, Astin, & Feurer, 2002; Schnurr et al., 2007). In addition, one study found that treatment gains were maintained an average of 5 years after treatment (Resick, Williams, Suvak, Monson, & Gradus, 2011). CPT and PE are recommended at the highest level in the VA/Department of Defense (2010) Clinical Practice Guideline for PTSD.

As part of the initiatives, VHA implemented competency-based training programs for VA mental

health staff who regularly provide treatment for PTSD. As of March 1, 2013, VHA had provided training in CPT and/or PE to more than 4,700 VA mental health staff, with additional staff trained each year, including in-person workshops and weekly phone consultation.

Cognitive Processing Therapy

CPT is a 12-session treatment based on a social cognitive theory of PTSD that assists individuals with identifying the meaning they make in response to a traumatic event and regaining a sense of mastery or control over their lives (Resick et al., 2002). CPT can be offered with or without a written narrative component, and the treatment can be implemented as an individual, group, or combined group and individual protocol depending on the needs of the individual (Resick et al., 2008). The treatment consists of three phases: education, processing, and challenging. Throughout treatment, the patient learns to use worksheets to identify ways in which the traumatic event(s) have affected his or her beliefs about self, others, and the world and to then challenge unhealthy beliefs, replacing them with more balanced views.



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The CPT training program began in 2007 with the creation of an adapted therapist manual for providing CPT to veterans (Resick, Monson, & Chard, 2008), a training manual and in-person staff training. A group therapy manual (Chard, Resick, Monson, & Kattar, 2008) was created in 2008, and the training was expanded to a three-day training. Following successful completion of the consultation with either two individual cases or one group, clinicians are then added to the CPT clinician provider roster. Program evaluation data for veterans completing a course of CPT with clinicians in the training program indicate clinically significant overall reductions of 19.5 points on the PTSD Checklist (PCL) and 12.7 points on the Beck Depression Inventory-II (BDI-II; Chard, Ricksecker, Healy, Karlin, & Resick, 2012). These outcomes are especially important given that these data typically represent the first cases with whom these therapists have conducted CPT.

Prolonged Exposure

PE, a specific form of exposure therapy for PTSD, is a cognitive behavioral treatment that is based on traditional exposure therapy for anxiety and emotional processing theory (Foa et al., 2007). PE has four main components: (1) imaginal exposure, the systematic and repeated imagined exposure to the trauma memory; (2) *in vivo* exposure, the systematic and repeated exposure to safe but avoided trauma stimuli; (3) psychoeducation; and (4) breathing retraining. PE works by helping patients approach safe but distressing stimuli in order to overcome fear and anxiety and to process the traumatic event. The training model consists of a 4-day experiential workshop that includes lecture, role-play, and video demonstration. Additionally, the training program has created educational videos and other resources for clinicians to use specifically with veterans. Eftekhari and colleagues (2012) reviewed program evaluation data from the PE training program and found that the training provided is effective. Specifically, clinicians report greater sense of self-efficacy and more positive outcome expectancy following the 4-day training with another significant increase after consultation is completed. Furthermore, program evaluation data for veterans completing a course of PE with clinicians in the training program indicate clinically significant overall reductions of 18.1 points on the PCL and 10.4 points on the BDI-II (Eftekhari, et al. 2012). Similar to the findings from the CPT program, these data are notable given that they reflect implementation by novice PE clinicians in training.

Future Directions

Recently, the CPT and PE training programs have been focusing on identifying ways to engage more veterans in the therapies through the use of technological advancements. PE mobile applications (PE Coach) for Android and iPhone were launched in 2012, and a CPT mobile application (CPT Coach) will be launched in the first half of 2013. Both of these apps are designed to facilitate homework completion and increase adherence out of session.

To further promote the availability of CPT and PE, VHA has developed a national initiative to implement CPT and PE telemental health services. As part of this initiative, staff have been hired or placed at sites throughout VHA to deliver CPT and PE through clinical video conferencing (CVT). In addition, training in the delivery of CPT and PE through CVT has been incorporated into the CPT and PE training programs. The Evidence-Based Psychotherapy for PTSD Telemental Health Initiative has enabled CPT and PE to be increasingly provided to veterans in rural areas and in high-demand clinics. Future areas of focus include the expansion of CPT and PE telemental health services and the implementation of computerized session note templates to facilitate documentation and allow for more

in-depth examination of the delivery of CPT and PE sessions.

Specialized trauma-focused evidence-based psychotherapies, such as CPT and PE, provide significant opportunities for successfully treating PTSD. VA's efforts to disseminate CPT and PE are designed to make these treatments widely available to veterans from all eras to help them reclaim their lives.

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Use of Telemental Health in the Provision of Evidence-Based PTSD Care for Veterans

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The U.S. Department of Veterans Affairs (VA) healthcare system is the nation's largest integrated healthcare organization. The VA's goal is to provide timely access to evidence-based, interdisciplinary, and integrated care for Veterans over the course of their lifetimes. In 2012, the VA served over 5.4 million Veterans, including over 500,000 Veterans with a primary diagnosis of posttraumatic stress disorder (PTSD; R. Hoff, personal communication, March 15, 2013).

The VA mandates that all Veterans have access to Prolonged Exposure (PE; Foa, Hembree, & Rothbaum, 2007) and Cognitive Processing Therapy (CPT; Resick, Monson, & Chard, 2007) and has launched a nationwide

dissemination program that trained over 4,700 staff in PE and CPT thus far. A recent comprehensive review of 11 VA studies of evidence-based treatments (EBTs) for PTSD documented large pre-post treatment effect sizes (Steenkamp & Litz, 2013). Moreover, seven of these studies were authored by therapists trained by the VA dissemination program, which provides preliminary support for the initial success and effectiveness of the training program.

Telemental Health

Cost of travel, varied work schedules, limited mobility, and other patient-end barriers can limit Veterans' access to effective PTSD care. These issues may be especially relevant for the approximately 40% of VA health care users who reside in rural areas. Telemental health, defined as mental health services and support via technology, may help mitigate some patient-end barriers. For example, clinical video telehealth—which refers specifically to real-time, interactive communication between patient and provider through a computer monitor—has already become a critical strategy for providing PTSD care to Veterans.

Studies indicate that clinical video telehealth can achieve comparable outcomes to in-person

psychotherapy for a variety of treatments (Backhaus et al., 2012). Initial VA pilot projects demonstrated the feasibility and effectiveness of providing EBTs for PTSD via clinical video telehealth (e.g., Tuerk, Brady, & Grubaugh, 2009; Tuerk, Yoder, Ruggiero, Gros, & Acierno, 2010). These findings are further supported by preliminary data from more recent randomized controlled trials (Morland, Hynes, Mackintosh, Resick, & Chard, 2011; Strachan, Gros, Ruggiero, Lejuez, & Acierno, 2012; Thorp, Fidler, Moreno, Floto & Agha, 2012).

In response to this emerging research, the VHA devoted \$11 million in targeted funding for expanding the delivery of EBTs for PTSD via clinical video telehealth. To assist providers in utilizing these treatments, the VHA created in-person trainings focusing on the implementation of clinical video telehealth, developed a community of practice, and provided online resources. Restrictions on travel and conferences for providers have challenged the VA's efforts in ensuring that providers hired or designated for EBT PTSD telehealth work have access to timely EBT training. At the same time, there has been an 85% increase in clinical video telehealth sessions with Veterans with PTSD between fiscal years 2011 and 2012 (Personal communication, E. Fielstein, June 12, 2012).

Challenges

One of the earlier challenges of disseminating trauma-focused clinical video telehealth was clinicians' apprehension regarding safety and efficacy. Some therapists were concerned that patients would become dysregulated while recounting a trauma narrative and that such dysregulation without an on-site provider would be dangerous. These incidents are rare, however, and clinicians who routinely practice telemental health indicate that this modality readily supports an effective, therapeutic, and safe relationship (Gros, Veronee, Strachan, Ruggiero, & Acierno, 2011). Moreover, there is evidence that therapist adherence to cognitive-behavioral protocols is



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comparable in clinical video telehealth and in-person modalities (Morland, Greene et al., 2011). Other important factors such as therapist competence and empathic expression (Frueh et al., 2007), patient and clinician satisfaction (Deutsch, Frueh, & Santos, 2000), patient attendance (Shore & Manson, 2005), and information retention (Morland, Pierce, & Wong, 2004) are similarly comparable between these modalities. These findings support the general safety of the modality, even though the base rates of problematic emotional dysregulation during sessions are too low for direct comparative study with in person modalities. Moreover, clinical video telehealth generally includes highly codified and thorough safety planning precisely because of these concerns.

Most of the challenges related to trauma-focused clinical video telehealth are logistical rather than clinical. There are a number of environmental issues crucial to the successful delivery of clinical video telehealth services, including preparation of the room and equipment, optimized lighting, and the provision of stationary chairs to reduce excessive body movement (Morland, Frueh, Pierce, & Miyahira, 2003). There are also challenges related to communication, such as scheduling between facilities, exchange of weekly self-report measures, and the importance of building relationships with support staff and referring providers (Tuerk, Yoder, Ruggiero, Gros, & Acierno, 2010).

Future Directions

Although the majority of PTSD-related telemental health research has focused on facility-to-facility telemental health, expansion of EBT directly into patients' homes via clinical video telehealth is part of a national strategy for meeting the future needs of Veterans. Other current telemental health innovations relevant to PTSD care include the use of mobile applications, such as PE Coach and CPT Coach (in development) to try to optimize the delivery of EBTs. More general mobile applications,

such as PTSD Coach, provide education and support for self-management of acute distress. A version of VA PTSD Coach is in development to deliver self-entered assessments to Veterans' electronic medical records. Additionally, several PTSD-relevant innovations are being piloted, such as secure patient-provider text messaging, applications that allow Veterans to self-schedule appointments, and a Health Management Platform capable of proactively facilitating patient-provider information exchange during periods of acute stress.

Conclusions

The VA system creates a fertile environment for telemental health experimentation and development. Whereas the VA can innovate and adapt on a nationwide scale, other health organizations, private practitioners, and third-party payers may be more tentative in assuming the risk of innovation and paradigm changes. To increase the national availability of clinical video telehealth services to trauma survivors, amendments to regulatory barriers (such as provider licensing and credentialing) and further investments in infrastructure are needed. Ideally, the transition to widespread telemental health will be an opportunity for improved access to high quality evidence-based care across various populations and contexts.

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Transforming Trauma from Violence into Healing: A Nation Responds

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We long for the words and the answers to ease the tremendous pain caused by the tragic loss of precious lives in Newtown, CT. Our collective grief and broken hearts are a heavy burden for us all to carry, and we are reminded of our motto at the Association for Trauma Outreach and Prevention (ATOP) Meaningfulworld: “Shared sorrow is half sorrow, while shared joy is double joy.” Healing and recovery require time, patience, and commitment as well as a deep level of persistent emotional mindfulness.

ATOP Meaningfulworld, a charitable organization affiliated with the United Nations, has responded to two decades of global and local disasters, looking for ways to help transform tragedy and trauma into healing and meaning-making through post-traumatic growth, emotional intelligence, and mind-body-eco-spirit health. The tragedy in Newtown is yet another that draws our attention to the need to: 1) raise consciousness and nurture resilience within our local communities; 2) focus attention on mental health care accessibility, availability, and acceptance; and 3) revisit our gun laws and procedures for firearm purchases.

The results of this work address the ultimate question in resolving emotional and psychological scars and promoting meaning, healing, hope, reconciliation, and trust: “What lessons have we learned from our traumatic past?” As Kalayjian and Anable (2006) so adeptly state, “The only healthy and permanent means of resolution for past traumas is through spiritual connections, through love, forgiveness, and acceptance” (p. 49).

Reflections on the Newtown School Shooting

There is a common thread that runs through the shootings in Aurora, Colorado, Virginia Tech,

Arizona, and even at Columbine: “Before virtually every single one, there was an undiagnosed or insufficiently treated mental illness” (Lipman, 2012, p. 1). Dr. Lipman recognizes the need for us as a nation to de-stigmatize mental illness and to not only be better equipped as teachers, parents, family members, and friends to identify signs of mental illness, but also to know how to effectively intervene. We must get over our discomfort with mental illness.



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Reliving the trauma only increases the symptoms. Deepak Chopra (2012) identifies suffering as “pain that makes life seem meaningless” (p. 1). He suggests humans are subject to “complex inner pain that includes fear, guilt, shame, grief, rage, and hopelessness” (p. 1). He offers the following reflection stemming from his own experiences with grief: “Hold each other. Don’t be afraid to ask for contact. Reach out and tell your loved ones that you do love them. Don’t let it be taken for granted. Feel your fear. Be with it and allow it to be released naturally. Pray. Grieve with others if you can, alone if you must” (p. 1).

Healing takes time. Offering another cause for hope, Chopra (2012) suggests that emotional balance for many victims can return to normal states within two years. He says the road to healing begins with taking a moment to pause and reflect on the choices we can each make as an aid to healing. He offers the following suggestions:

Hold each other in loving awareness; speak gently; resist viewing negative images over and over; walk away when the conversation contains negativity; keep your life as structured as possible—this is

especially true when dealing with children in the aftermath of tragedy; try not to be alone—eat meals as a family, with friends or neighbors, allow friends to offer consolation even when being around others is painful; forgive yourself when you feel like a victim, but take steps to grow out of victim thinking; allow for others’ point of view. It

is possible to become involved in our own healing (Chopra, 2012, p. 1).

Parents, teachers, caregivers, and family members, who have been directly or indirectly affected by the Newtown tragedy, are reaching out for support from the community and the mental health system at large. One mother shared her worry about the isolation and depression faced by many children with Asperger's syndrome and the challenge of getting proper care (A. Kalayjian, personal communication, January 4, 2013). Parents also worry that the specific care their children require will no longer be covered by insurance companies once they reach a certain age, for example, as early as nine years of age in some states (The National Conference of State Legislatures [NCSL], 2012).

An Integrative Healing Model

Health and healing may be approached using a 7-step Integrative Healing Model (IHM) (Kalayjian, 2002, 2012). IHM is utilized through the following steps: 1) assess levels of distress; 2) encourage expression of feelings; 3) provide empathy and validation; 4) encourage discovery and expression of meaning; 5) provide information; 6) encourage eco-centered connection; and 7) provide breathing and physical release exercises, releasing fear, uncertainty, and resentments. Natural products such as Bach Flower Remedies aid in the healing process. Breath is used as a central tool for self-empowerment as well as for engendering gratitude, compassion, faith, strength, and forgiveness in response to trauma.

Summary of Responses from New York State Psychologists

As part of the New York State Association listserve, where more than 700 psychologists brainstorm and exchange their feelings and views, the following was observed regarding their response to the Newtown shooting: In the beginning the discussions were focused on getting the facts in order; then a lengthy debate on the pros and cons of gun control; then the discussion turned to the need for proper psychological care and intervention; and finally an assessment of issues relating to the lack of reimbursement by insurance companies and the heavy stigma associated with mental health care.

Summary of Responses from the New York Dispute and Mediation Group

The New York Dispute and Mediation community has distilled a conflict resolution response to mass shootings in general. They do not pretend that they or anyone else has the influence to convene, organize, or resource the response, but they are mobilizing around their intention to convene collective and individual networks to reduce mass shootings in the United States.

They have offered the following conflict resolution process and strategy as an intervention for future tragedies:

1. Work with the Institute of Medicine, National Science Foundation, or the National Academy of Science to conduct joint fact-finding on what we know and do not know about the causes, triggers, and public policy responses to mass shootings.
2. Convene a policy dialogue to develop consensus on policy options to reduce mass shootings.
3. Convene a Values Dialogue between gun control advocates and Second Amendment advocates.
4. Conduct conversations about guns, safety, and freedom in religious institutions, neighborhoods, and communities. When community conversations are well led and resourced, they can produce common visions and plans. Community conversation and study circle tool kits on gun violence can reduce citizen despair and create moral consensus on violence and freedom.
5. Conduct city or regional dialogues that integrate options from neighborhood and community conversations into municipal and regional approaches.

Michael Moore's provocative article in the *Huffington Post* (2012) asks the question, "Who are we?" Perhaps now more than ever we must continue to cultivate and celebrate our collective values of kindness, compassion, empathy, and forgiveness. International human rights activists and *Huffington Post* columnists Craig and Marc Kielburger ask: "Can good come of Newtown's grief?" (Kielburger, 2012). As Viktor Frankl stated in 1946, there is a deeper meaning in all tragedies. The Kielburger brothers too observed that in the wake of this tragedy, young people have proven that strength, resilience and compassion can prevail (2012). They recount the outpouring of goodness and immeasurable acts of kindness that have come from our collective grief.

Students have responded with kindness and meaningful action, including turning handwritten notes into 1,000 paper cranes. Young people have started Facebook groups such as "26 Acts of Kindness," inspiring random acts of kindness like putting change in a stranger's parking meter, clearing the snow off a neighbor's car, and offering 26 hours of community service. Craig and Marc Kielburger (2012) suggest that supporting young people in their desire to help "is not to take away from the necessary process of remembrance and grieving—even from afar—but it does show the power of good" (p. 1). Through our grief, it is possible to find goodness and strength. This also helps us bring meaning to these atrocities that seem to negate all that is right in the world (Kielburger & Kielburger, 2012).

Dr. Jodie Kliman (2012) proposes that as health

professionals, educators, and parents we need to lobby for change on one of the worst public health crises in our nation, with the 30,000 people a year killed and many more injured by guns. She believes we are well placed to lobby for true gun control and to ask: Why are assault weapons so much easier to access than community-based mental health services, especially for children? Similarly, Dr. Martin Seligman (2012), former president of the American Psychological Association, argues in the *Washington Post* that the only realistic hope for avoiding many more Newtown tragedies is to increase taxes on guns and strong restrictions on their availability. Dr. Seligman (2012) finds that despite billions of dollars in funding, drugs and therapy offer disappointingly little additional help for the mentally ill than they did 25 years ago. He concludes that the real leverage is not the progress of reducing violence through either helping the mentally ill or curbing violent impulses, as these are slow coming, but reducing access to guns.

Nevertheless, there are too many individuals with severe mental disorders who are not being treated. According to the National Institute of Mental Health (Fuller & Torrey, 2012), 7.7 million Americans currently have been diagnosed with schizophrenia, schizoaffective disorder, and bipolar disorder, but 3.5 million of those do not receive ongoing treatment. Furthermore, 350,000 or 10 percent of these individuals become societal problems because they never receive treatment. They are among one-third of the homeless population and one-fifth of the inmates of jails and prisons (Fuller & Torrey, 2012). According to a 2010 study conducted by the Treatment Advocacy Center, there are over three times more severely mentally ill individuals in jails and prisons than in hospitals (as cited in Fuller & Torrey, 2012). Another part of the issue that requires immediate attention is that treatment is lacking and the availability of public psychiatric beds in the United States continues to decrease.

A Call to Action

President Obama (2013) called for meaningful action, stating, “We can’t tolerate this anymore. These tragedies must end, and to end them we must change” (p. 1). It is often said that it takes a village to raise a child; therefore, it takes a country to care for our mentally challenged (Kalayjian, 2012). Collectively, we can all work together to take the following steps toward recovery:

1. Work on prevention, NOT reaction.
2. Meditate and mediate, NOT medicate.
3. Rehabilitate, DON’T incarcerate.
4. Demystify violence (violent computer games and violent movies). Don’t be fooled, there is nothing sweet about revenge—it will impact us negatively for generations to come.
5. Get annual mental health and spiritual

checkups—you are more than your physical body.

6. Express your feelings openly; remember, “Real men cry, they don’t kill,” and “Shared sorrow is half sorrow, while shared joy is double joy” (Swedish proverb).
7. Remember to love and learn to forgive; violence begets more violence, so take yourself out of the vicious cycle.
8. Help one another; remember when one helps another, BOTH become stronger.
9. Don’t stigmatize mental health care; make it more accessible, acceptable, and available, and that includes insurance reimbursements.
10. Stop violence on all levels, especially by police and by nations that start wars.
11. Increase the number of school psychologists, social programs, mental health care options, expressive arts and art therapy programs, as well as after-school programs.
12. Revisit gun laws and needs, and make sure the prerequisite background check and psychological assessment is done for all household members, not just the one who is purchasing the gun.

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Assessment and Treatment of Complex PTSD

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Patients frequently present to clinicians with complaints of adverse impacts from trauma. A subset of these individuals are frequently misdiagnosed as having Post-traumatic Stress Disorder (PTSD) or major depression. Van der Kolk (2001) relates that traumatized, treatment-seeking patients suffer from a variety of psychological problems not included in the diagnosis of PTSD, such as depression, self-hatred, dissociation, depersonalization, aggression against self and others, problems with intimacy, and anhedonia.

As a test of the construct, it is interesting that the DSM-IV field trials (van der Kolk et al., 1996) demonstrated that it was not the prevalence of PTSD symptoms themselves, but depression, rage, self-destructive behavior, and feelings of shame that distinguish a treatment-seeking sample from the non-treatment-seeking community sample with PTSD. Seventy-seven percent of the treatment sample suffered from significant dysregulation of affects and injuries, including aggression against self and others.

Van der Kolk (1996) notes that numerous studies demonstrated that no large-factor analysis has been conducted across a variety of trauma

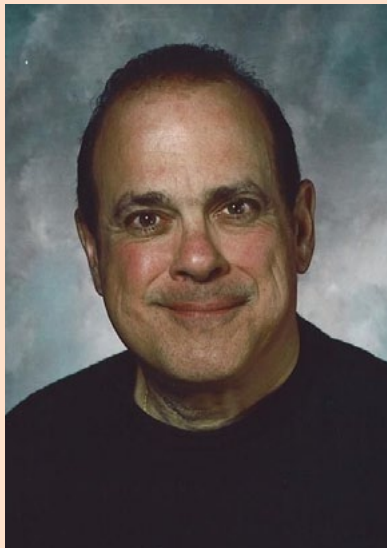
populations to test whether the diagnostic criteria for PTSD uniquely capture the psychological damage that occurs in response to psychologically overwhelming experiences. There is the problem of lack of homogeneity of classifications in the DSM-IV. Moreover, the PTSD field trial failed to measure other Axis I or Axis II disorders in its sample of 528 traumatized individuals.

Thus, the design of the field trial was unable to demonstrate that the criteria delineated in the diagnosis of PTSD captured the most essential elements of human suffering that occurs in the wake of trauma.

Course of Trauma

There is little indication that children outgrow their early problems with trauma (i.e., history of child abuse and child maltreatment), and they have repeatedly been found to suffer from profound and pervasive psychiatric problems, including neuropsychological changes throughout the lifespan (Levitan, 1998; McCauley et al., 1997; McCord, 1983; Roeseler & McKinzie, 1994; Widom, 1997).

Of interest is van der Kolk's discussion of disorders of extreme stress (DES NOS) or complex PTSD. This concept has also been written about by Herman (1992), who associates complex PTSD with prolonged repeated trauma where individuals perceive or are in fact held captive. This may apply to situations in which children are subject to egregious abuse by



Michael J. Perrotti, Ph.D.

an authority figure who is in a position of trust. The children are fearful to leave these situations and thus are in a sense “a captive” in the situation. That may trigger complex PTSD syndrome.

This writer in his practice has seen individuals with complex PTSD (i.e., prolonged or repeated trauma) who indeed manifest the symptomatology of DES NOS (i.e., impaired affect regulation) and chronic destructive behavior (i.e., self-mutilation, substance abuse, dissociation, amnesia, somatization, alterations of relation to self, distorted relations with others, loss of sustaining beliefs). These individuals at times present with suicidal and homicidal ideas so they may pose a danger to self and others.

Duty to Protect

With respect to forensic psychologists in these situations, even though they are doing assessments, it is incumbent upon them to protect the individuals if symptoms rise to the level of suicidal or homicidal ideas. This involves crisis intervention and coordinated efforts with any treating therapists.

Further Comments on Construct Validity of PTSD

The DSM-IV field trials of PTSD found that DES NOS had a high construct validity (Pelcovitz et al., 1997). The earlier the onset of trauma and the longer the duration, the more likely people were to suffer from high degrees of all of the symptoms that make up the DES NOS diagnosis. This is an important consideration with military conscriptees who are faced with multiple reenlistments or long terms of duty in areas with high combat activity.

Assessment Protocols

It is incumbent upon psychologists to take a detailed history of these individuals. One should not stop at the point of an individual presenting with a specific trauma and the impact of said trauma. One needs to examine the history of other traumas and the traumatization experience in total. Moreover, it is critical to obtain information on the degree of prolonged exposure to traumatic event(s).

Individuals in the aforementioned population of DES NOS present with suicidal and homicidal ideas and affective dysregulation. Moreover, neurobiological studies show that there are alterations in the brain structures regulating anger and impulsivity. In addition, there are neuropsychological deficits in executive function. These areas require, at the very minimum, a neuropsychological screening test and neuropsychological assessment to fully assess all of the diagnostic entities possible. There is a substantial body of literature on the neurobiology of PTSD.

Summary

In sum, many traumatized individuals present to a clinician's office with apparent symptoms of PTSD and/or major depression, frequently with comorbid substance abuse. However, if there is a history of an individual perceiving that they were a captive or being in captivity with traumatic events in addition to having been subjected to prolonged trauma, then one is looking at the construct of complex PTSD. The assessment then has to proceed toward assessment of suicidality and homicidality as well as neuropsychological assessment and assessment of affective dysregulation and dissociation.

It is hoped that this article and assessment protocols will be useful to psychologists in assessment and treatment of these difficult populations. Treatment management is exceedingly important, even if one is a forensic examiner, in that one needs to “do no harm” at all cost to protect our patient.

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One Woman's Story of How the Legal Nightmare Begins

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Context is critical for everything in a family court. Thus, taking an actual history cannot be minimized. I always ask a client to describe the first real argument she had with her spouse before she was married. I have found that much does not change from that first argument to the “final straw.” Through my representation of battered mothers for many years, I have learned in my legal practice what many psychologists are taught in their first year of clinical work, that is, to take a good history. The problem is that specifics are critical because battered women invariably minimize and, as a result, are not terribly good reporters of history. Thus, psychologists who do therapy for women and psychologists who do evaluations for the court or for lawyers must ask some probing historical (not hysterical) questions, and recognize that the process is not necessarily linear for women who are emotionally or physically battered. One question I ask is, “How did you resolve your first real dispute with your husband, even before you were married?” I find that the relationship mechanisms existing long before marriage continue to exist well into the marriage.

Women who end up being battered seek to please before marriage. They set their own needs aside, and capitulate and absorb. It begins with empathy for their husbands' feelings and becomes a pattern of setting their own needs and feelings aside. This pattern gets exploited by their emotionally battering partner and never seems to change. I always ask women to write a history while most attorneys ask women to write the impossible—a chronology or a list of abusive events. There is no such list. There is the context in which events occurred. I thought it might be interesting for psychologists to read one woman's story of the time before divorce, before custody became an issue. It may answer the question that so many of us ask, that is, why didn't the woman leave long ago. This story illustrates how the abusive male feels as he gets ready to exploit his wife, to attack her as “unstable” just as she is trying to get her bearings, to figure out what happened and how to manage her new life.

I have found that the women at the time of marriage are actually more stable, healthier, and more capable of flexibility and therefore probably start out more emotionally healthy than their husbands, not

realizing the emotional stakes for them over time. The flexible strong woman begins to lose her center, but there is no one defining moment until for almost an inexplicable reason she leaves. I see anecdotally that batterers seem to choose strong women who, over the course of the emotionally battering relationship, become insecure and dependent. Psychologists can help courts to understand that these men are rigid and unyielding and less emotionally healthy, and to show how and why it may look otherwise. When most of these women enter the legal world, there is a naïveté, an expectation that



Toby Kleinman, Esq.

her lawyer will understand and the court will fix things. Her stance is usually filled with conclusions rather than with the substance of what happened and how she let it occur. Untrained lawyers and courts do not understand that these men are masters of deflection, and put off to others what is true of themselves; that they spin things with their wives as the cause of the problems; that their emotional abuse has caused a learned helplessness as women, through years of struggle, have tried to adapt and accommodate to their husbands' often escalating demands. By the time they leave they have become convinced of how harmful their spouses are to them and to their children and there is an unrealistic expectation that others will instantly understand. When others don't get it, the women appear unstable, and thus their husbands' statements about their instability look real to the untrained observer of the court.

It is critical for these women to first have help in unraveling their history—from how they started to where they ended up. I discuss what their expectations were for a marriage when they were young and how they got away from that, and try to figure out what happened along the way. The women's valiant efforts at dispute mediation in the marriage, often resolved by her capitulation, are often at the heart of this. Psychologists can teach lawyers how to unravel the history and to show how the husband has spun a web of lies against her. They can help show that her attempts to appease the batterer's unending insecurity and self-centeredness have seemingly caused her to become unraveled. Psychologists need to probe to try to figure out how it began so they can explain the mechanisms they see at work.

This is a common circumstance and here it is, one woman's story:

Tears stream down my face as I stop the car to make the phone call, my heart racing. My instincts tell me not to stop. I left because I was forced to leave and my instincts tell me not to call home now. I am certain that if I call, I will feel worse. Yet I feel an intense pressure to speak to him. I try to assess the situation. I am glad that I am gone, yet I am frightened because I had finally been so provoked that I actually left. I made many threats in the past ten years. I finally carried one out.

This afternoon feels different somehow. I know I am really leaving for good, not just for the weekend, as I said. I cannot recount the occasions I felt like leaving. But today, I packed a suitcase, put the children in the car and made an exit. Why, then, am I feeling so confused? Why am I having so much difficulty driving the car? I know I have been unhappy for a long time. I know he has also been unhappy. Can I not stand to risk being rejected if I call? Will I run back out of fear? It makes no sense. Is everything I am feeling based on economics, because I believe his lie that I am incapable of sustaining my three children and myself? Randy and Ramona are asleep in the car. David, who is eight years old, is asking me if I am sad. I mumble something barely audible. I can hardly see to drive through my tears. Of course, David knows I am unhappy. Of course, he knows there is trouble between his father and me. But he did not witness the scene this time. At least I feel good about that.

This morning I behaved like a crazy person. Was I crazy? I feel as if an explosion is about to take place inside my brain. In an attempt to feel better, I stop the car. I make the call. There is no answer. The pressure is building. My guilt is rising. Did he have another heart attack? I get back on the road. I am driving to Vermont! I have a destination! That is different from the past. I never before told anyone. This time I called my parents. I called right away. I called when my insides felt like they were ripping apart. I know that if I did not call, then I would not go! "Be involved," I said out loud to myself. "Call your mother," I urged myself. Tell her you have a rotten son-of-a-bitch husband. Tell her you need help. Tell her you want to run away from yourself. Tell her that if you stay another day, you will do something drastic. I have got to protect the children. You can throw your own life away, but you do not have the right to destroy the children. They will be destroyed if you stay.

This morning I shouted at him, "David is unhappy and depressed. Randy is a mess. He is starting to stutter and stammer with you!" I screamed at him, "Ramona is such a tiny baby. I can spare her if I leave now." With that, I had called my mother in Vermont to ask if I could come for the weekend for which she had previously invited us. Even as I called, I wondered if I had the right to leave. Maybe I am the source of all the kids' ills. After all, I had started the scene this morning.

It was I who woke up ready to fight. "I hate you," I had said. "You are so mean and selfish. How long can I continue to fight you? How long can I continue to prove to you that I am a good person? Why is it that I can never do enough for you? Why is everything always my fault, yet I always feel sorry for you?" I had shouted. As I feel the anger now, my tears subside. I tell myself that he loves me. I tell myself that he will ask me to come back. But I know better. I know I will, in the end, feel sorry for him. I will, in the end, apologize for having hurt his feelings though he destroyed mine. People will think that I am the strong-willed one and that he is meek and giving. That is the image he forced me into creating. I have been living the lie for so long now, it almost feels like me. I must break that lie. I must break it to protect the children from losing touch with their reality as I feel I am losing mine.

I have only driven a few short miles in the hour I have been driving. I think I should turn back. The little ones won't know the difference. Randy has never been to my parents' country house in Vermont in his three and one-half years (how many times he refused to go). David tells me about the fun he is going to have when he gets there. He enumerates all the things he loves about Vermont. They all involve Grandpa—my father. I feel glad that David has experienced the love of my father. He has had glimpses of generosity and love from a man. He has seen that a man can really care.

I feel that I must go on, but I am not sure if I can. I cannot stop crying. The pressure in my head is mounting. I cannot stop the pain. I know I would end up crazy if I stayed. Why, then, am I having so much trouble leaving? It makes no sense. He was always angry with me. He was always angry with the kids. I was always trying to prove to him that he had no reason to be angry. I was always trying to prove my worth to him. He was constantly denigrating my family and me. He was always certain that he knew everyone's motives for their behavior. I had swallowed that lie for so long now it would be difficult to break it. I must focus on the children and their needs.

Even as I drive, I continue to ask if he is right. Are my parents awful people? I hate myself for even asking. It has always been the knowledge that I could count on them that has sustained me in the past, when I was hurt. I know they will help if I can only get there. I stop the car again and get out to make a call in private. David wonders whom I keep calling. I mumble another answer. My eyes are so puffy I can barely see. I finally know that I can't drive anymore! The pressure in my head has become unbearable, so I turn off the road. There is a gas station. I stop and step out of the car to make another call. As the phone rings, I can already hear the tension in his voice. I hear a quiet "hello." I slur over apologies for starting a fight this morning. He is cold. "I am not the same person I was when you left me

an hour ago,” he tells me, “I took a walk to the post office after you left. I felt free, Ellen. I feel terrific.”

Rejection! I knew it! I feared it! I start to say that I'll go back anyway. I'll show him I am a good person. I'll show him that he is free with me as a wife. I force myself, instead, to say goodbye. I urge myself on. I drive onto the highway. The scenery is a blank to me. I try to stop the tears, but they continue to flow as the pain of the rejection smarts! He feels good. I replay our conversation. I feel agony and he feels good. As always! He is always happiest when I hurt. I wonder why; I wonder why I stayed so long. He is selfish. He is arbitrary. He is incessantly angry with the children and full of wrath toward the world around him. I decided to continue in the same direction. Tears are worse than ever. David expresses concern. Randy wakes up and so does Ramona. I am not certain if I can drive any longer. Randy is cranky. David tries to entertain him. David tells Randy how much fun Vermont is.

I feel like I must turn around. My head is pounding! I can hear my heart thumping in my ears. The noise is crushing. Certain I can drive no more, I stop the car again and I call him. There is no answer. “He left again,” I sigh out loud. I had better call Dad and tell him I am going home. I put my call through. It seems to be taking forever. The phone rings and rings and rings. Finally, “Hello” “Dad, I don't know what to do. I can hardly drive.” “Keep coming, Ellen,” he says, “Drive slowly and carefully.” He reassures me that it will take only a little longer that way. “You might as well come, since you are on the way.” He says to come, so I will.

I feel like a robot with no mind of my own. I reflect on my parents' invitation to visit the country. It was so timely. I had refused at first. But this morning, I just could not bear things any longer. I had called to accept the invitation, but I had said nothing to them about our fight. I merely accepted an invitation to visit. They know I am leaving him and leaving the marriage.

I am not sure I can even bear to think about it. I really must be cracking up. I feel relieved, as if I needed someone to make a decision for me. I have three little children who need protection. He lies, he deceives, and then he swears so sweetly that he never said or did anything at all. The children need a sane existence. They need to learn to trust what they see and what is real or not. I try not to think. I try to stay free from feeling. I just want to drive and to get there safely. I watch the odometer. I keep guessing how much further I have to go. I sing songs. “When you walk through a storm, keep your head up high, and don't be afraid of the dark.” I cry. I try to think of a happy children's song. I draw a blank. Randy liked that song and asks me to sing it again. I do.

I drive on. As I approach my exit I know we will make it! Only fifteen more minutes. I drive on. I sing for Randy. I round the bend into their little village. I see the

house. Mom rushes out. We hug. I did it! I left him. We are helped out of the car and into the house. It feels free on Lohiya Drive. The kids are glad to be here. I made it and I am okay. Somehow, I know I can make it now.

Write a chronology of cruelties! How can I do that? I cannot indulge myself and expose my family. I want to get on with the business of living, but the lawyer insists. He must have a list of cruelties on which to build a case. It has been three months of living apart. He has given me almost no money to support the kids or myself. I am living with my parents in North Bergen. It has been a difficult time. My feelings are quite tender. Others easily sway me. I am often not in touch with my feelings. I only know that I can never again be his target. Never again can I allow him to spew his wrath upon me. Never again will I permit his diabolique to destroy my sense of self, my feelings, and my critical judgment.

My lawyer wants a chronology now, and I can't seem to get off the first page. We got married. We had lived together for six months before our marriage. I knew he was rigid. I knew he was demanding and somewhat unyielding, but I thought he was also capable of love and caring. I believed in what he told me. I believed in his intentions, which spoke of love and commitment, although his behavior said hate. His diabolique! I felt it for ten years. I cursed it for ten years. I questioned it for ten years. Yet, I never failed to believe in it. He says he loves me, therefore he does. He has sent no money and speaks cruel words to me. Yet, when I think of him, I feel sorry for him and not for myself. I am certain he does not mean his hateful words. I feel that if I explain to him how awful his words are, and how confusing it is to say something one day and deny saying it the next, that he will promise never to do that again. I feel it, yet I know I am wrong. I know that I have explained it hundreds of times. I know he has apologized for his humiliations countless times. He has sworn his love and promised to end the contradictions between his words and deeds. I thought he had integrity. I have learned he has none.

I do not want to spend any more time dredging up the past. I want to start to live. But he won't send money and I have no means of support. I don't have a college degree. I have three children, one an infant, so I have to fight. He promised he would get the kids. He promised everyone would know I'm unfit. I am terrified. Here I sit, reflecting on my past. Ten years—a chronology.

This woman's story tells it all. There is a critical need for the psychologist and the lawyer to be able to explain the distinctions between the batterer's words and deeds, to unravel the spin of assumptions about what he claims to be true versus what has actually occurred (i.e., the cruel words followed by apologies or claims that things were never stated). Only by a careful understanding of history can this be done successfully, as women go from robotic to

hysterical. What I know from my practice is that where there is understanding, these women improve and begin to show they are “normal” within a short period of time and the men who batter show their true colors when they no longer are able to cause the woman to appear unstable. A good history is the centerpiece of teaching the court.

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Identifying and Managing Burnout, Compassion Fatigue and Vicarious Traumatization

Mira Brancu, Ph.D.

It's not a question of whether or not caregivers will hurt in the course of treating trauma, but how they will handle it when it comes up. (Bruner et al., 2009)

Burnout, secondary traumatic stress (STS), compassion fatigue (CF), and vicarious traumatization (VT) are all interconnected constructs that have been applied to negative emotions and thoughts that often arise in response to working with challenging trauma populations. Burnout was initially studied in the world of business and industry and later applied to human service professionals, particularly those who work with trauma (Maslach, 1976). Burnout describes the physical, emotional, and mental exhaustion caused by a depletion of resources to manage work stress (Maslach & Goldberg, 1998). For therapists, the behaviors associated with burnout can include irritability, cynicism, callousness, withdrawal/isolation, dehumanizing or over-intellectualizing patients, reduced sense of accomplishment, and decreased work performance (Kahill, 1988).

Secondary traumatic stress (STS) is defined as the natural stress response to helping or wanting to help a traumatized person (Figley, 1995). This can be equated to the normative initial response to direct trauma exposure, and it has been argued that symptoms of STS parallel those of PTSD, including re-experiencing a patient's traumatic event through thoughts, feelings, and images; avoiding or feeling numb

to emotions that remind the provider of the traumatic event; and hyperarousal symptoms such as sweating, sleep problems, or increased startle response. Similar to PTSD, some people recover quickly after exposure to traumatic content, while others develop more lasting distress.



Mira Brancu, Ph.D.

According to Figley (1995, 2002), those who develop more significant symptoms may be at risk for compassion fatigue (CF), generally described as the combination of (a) work-related burnout and other occupational stressors, (b) STS, and (c) prolonged exposure to others' suffering. The symptoms of CF can mimic the combination of PTSD and burnout symptoms, including re-experiencing and thinking about patients' traumatic experiences and other work-related matters, professional isolation, avoidance of supervision or discussing related patient concerns in supervision, alcohol or drug use/abuse, over-identification with or anger at patients, increased emotional reactivity in or out of session, decreased job productivity and focus, increased feelings of incompetence, exhaustion, and depression/anxiety/anger.

Finally, vicarious traumatization (VT) has been defined as repeated empathic engagement with trauma survivors, leading to a disruption in the providers' meaning-making system and hope (McCann & Pearlman, 1990).

There continues to be disagreement in the literature about whether a difference exists between CF, STS, VT, and burnout. For example, Stamm's (1999) critique suggests that perhaps the controversy is not

whether compassion fatigue exists, but rather what it should be called. In contrast, more recently, research by Devilly and colleagues (2009) suggests that both STS and VT are better accounted for by the burnout construct. Despite the disagreement in the literature, one thing is clear: Those who work with trauma patients have particular risks for developing personal distress in response to their client's stories, which may become problematic if not identified and managed early.

Risk Factors

Individual vulnerability factors are still not well researched or understood, and to the author's knowledge, there are no published studies to date specific to Early Career Psychologists (ECPs). However, there are some risk factors that have been identified that may be particularly relevant to ECPs:

- Failing to recognize or attend to negative emotions and thoughts about our work (Warren et al., 2010) and allowing distress to progress unchecked (Barnett & Cooper, 2009).
- Long hours, large caseloads, and higher degree of exposure to traumatized patients (number and/or severity), especially involving survivors of violent or human-induced trauma and/or children (Sprang et al., 2007).
- Personal trauma history (Sprang et al., 2007); however, this has received mixed results in the literature.
- Poor, inadequate, or insufficient supervision (Pulido, 2012).
- Younger age and fewer years of professional experience (Sprang et al., 2007; Craig & Sprang, 2010; Smith & Moss, 2009)
- Less education (Sprang et al., 2007) or experience working with a specific sub-population (Pulido, 2012).
- Being female (Sprang et al., 2007).
- Professional and emotional isolation (Smith & Moss, 2009) and insufficient self-care (Barnett & Cooper, 2009).
- Lack of therapeutic success (Smith & Moss, 2009).

One can imagine that a number of the risk factors above are likely to be interconnected. For example, lack of adequate supervision and professional isolation could make it difficult to obtain feedback about personal risk factors related to training, personality traits, and appropriate expectations for treatment outcomes.

Resilience Factors

A number of resiliency factors have also been identified in the literature. First, the therapist's ability to construct meaning in the face of stressful experiences (Sprang et al., 2007) or to engage in growth and transformation while witnessing the patient's own recovery during the course of therapy have been shown to be related to clinician resilience (Hernandez et al., 2010). Second, a sense of job autonomy and control has been found to reduce burnout (Sprang et al., 2007). Third, self-awareness and prioritizing self-care is critical to any therapist, regardless of the patient population being served (Sprang et al., 2007). Fourth, senses of achievement and emotional disengagement have been shown to strengthen resilience (Figley, 1995). And finally, though perhaps most critical to ECPs, is that specialized training in trauma work and utilization of evidence-based practices have been found to reduce the potential for burnout (Craig & Sprang, 2010; Sprang et al., 2007).

In addition to these, a well-developed support network, including colleagues, consultation, and supervision are especially critical for mitigating burnout and compassion fatigue for ECPs (Sprang et al., 2007). Although there is a paucity of empirical evidence on the psychological impact of supervision on the supervisee, there has been much research on the importance of high quality supervision and colleague support for normalizing reactions, feelings and experiences; providing validation; providing information about the nature and course of trauma reactions; identifying potential transference and countertransference issues; and recognizing problematic symptoms or interactions (Sprang et al., 2007; Slattery & Goodman, 2009).

Self-Care and Personal Intervention

Research has shown that up to 75% of psychologists experience distress at some point in their careers, with nearly 60% of them stating it was enough to affect the therapeutic relationship. Almost 37% reported it resulted in decreased quality of care, and almost 5% admitted to delivering inadequate care as a result (Smith & Moss, 2009).

As psychologists, self-care is something we are good at telling others to do, but we often forget to practice it ourselves. Yet, self-care is a critical tool for keeping ourselves in optimal condition to provide therapy to others, especially when working with trauma survivors. Furthermore, we have an ethical mandate to attend to our own wellness for the benefit of our patients. Below are some suggestions to consider implementing in order to routinely manage and prevent distress and impairment as a result of trauma work:

- Reduce arousal through relaxation

- Reduce isolation through social support
- Increase self-awareness by assessing yourself for symptoms and learning from them, especially through the use of consultation and supervision
- Seek mastery of skills when needed through further supervision, training, and education
- Seek and value personal therapy well before you reach a critical level of distress or impairment
- Manage high empathic engagement (i.e., over-identifying, overreacting, etc.) through distancing emotionally when necessary
- Acknowledge that if you work with trauma patients, secondary stress reactions are normal, not a sign of weakness, and will require intentional planning for ongoing self-care
- Monitor what you use for relaxation or entertainment and assess their usefulness (e.g., substance use, sleep, movies, video games)
- Consider self-care as a multi-dimensional daily intervention by developing a plan for physical (exercise, sleep), social (consulting, vacationing), mental/emotional (positive self-talk, reaching out), occupational (finance management, managing risks) and spiritual needs (mindfulness, forgiveness)
- Have transitions between trauma patients at work as well as from office to home (e.g., visit with colleagues during day, changing clothes when come home)

By making self-care a priority and implementing strategies to increase resiliency, we reduce the risk of developing burnout or compassion fatigue over time. Below is a short list of free assessments to help you evaluate your current level of stress and resilience. If you have not made self-care a priority or if you simply wonder how well you are doing with managing your current level of stress, take these quick surveys and develop or build on your self-care plan as needed.

- Provider Resilience App: <http://www.t2health.org/apps/provider-resilience>
- Personal assessment of your level of compassion satisfaction and fatigue: Professional Quality of Life Scale (ProQOL; Stamm, 2009): www.proqol.org
- The Perceived Stress Scale (Sheldon, 1994): www.mindgarden.com

In addition, be on the lookout for the Division 56 Early Career Committee webinar on this topic, coming

soon!

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Mira Brancu, Ph.D., earned her PhD in clinical psychology from The Catholic University of America in Washington, DC in 2009. She is a member of the North Carolina Psychological Association Colleague Assistance Committee, focused on psychologist wellness. She is the managing director of the Mid-Atlantic VA Mental Illness Research, Education and Clinical Center (VISN 6 MIRECC) post-deployment mental health registry and an Assistant Professor in the Psychiatry Department at Duke University. Dr. Brancu is also temporarily serving as the Acting Director of the VISN 17 (Central Texas) Center of Excellence (CoE) on Research of Returning War Veterans.

Vicarious Trauma

Ani Kalayjian, Ph.D.

After several humanitarian rehabilitation missions,
I am finally home, sitting on my bed and
Wondering to myself—how do I feel?
Am I numb from all the traumas I've witnessed?
Am I frozen, devoid of feelings?
Am I so sad that I have managed to push
All of my feelings down? Or is this vicarious traumatization?

I came face to face with the bulging eyes of poverty in DR Congo,
I witnessed the chapped lips of dehydration in Sierra Leone,
I cried with the neglected and abused woman in Pakistan,
I helped the young man with no legs in a village in Armenia,
And I wiped tears from the cheeks of a child in Rwanda...

But afterward I would always return home. I have a comfortable home to come to,
Unlike all the people I worked with.
I've returned home but isolate myself for a while,
Confine myself to the four corners of my comfortable home...

Was I feeling the guilt of having economic comfort?
Or of the privileges I enjoy?
Was it the disparity of education that I noticed destroying nations?
Or was it vicarious trauma?

My Armenian ancestors endured being homeless.
They were driven out of their homes, forced to walk for months
Through the deserts of Arabia on a march to their death.
Where is God, I wonder, when I am working in these traumatized countries?
But now I realize that all of the human race—
Every nation—has experienced the pain and sorrow
Of being uprooted, conquered, and destroyed,
Only to start building all over again.

I also witnessed the raw, unadulterated, beautiful beaches in Haiti,
The brilliant, peaceful stars in Lebanon,
The giant mountains of Kenya,
The breathtaking waterfalls of Sri Lanka, and
Armenia's indomitable Mt. Ararat.

As I sequester myself to reflect,
Balancing the good and evil,
Weighing the positives and negatives
Of all that I've witnessed, I remain in wonderment
As I ask myself: Do we really need the evil to be able to appreciate the good?

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 form

International Committee

Elizabeth Carll, Ph.D., Chair

The committee has organized a symposium for the 2013 Annual Convention in Honolulu, "International Perspectives on Intervention and Recovery Following Violence and Disaster"—with participants Elizabeth Carll, Chair, United Nations NGO Committee on Mental Health; Vincent Sezibera, National University of Rwanda, who will discuss trauma, resilience, and vulnerability in post genocide survivors; Atle Dyregrov, Center for Crisis Psychology, Norway, who will discuss the 2011 Norway terrorist attacks; and John Thoburn, Seattle Pacific University, who will discuss his work in the aftermath of the Haiti earthquake. The symposium is scheduled for Thursday, August 1st, at 10:00 AM in Room 308B in the Convention Center.



Elizabeth Carll, Ph.D.

children and adolescents. Previously, she was an intern in the psychiatry departments of Vietnam National Hospital of Pediatrics and Singapore General Hospital.



Linh Phuong Luu, M.S.

Linh Luu will be presenting a poster on *Contextual and Person Factors in the Relationship with Trainees' Commitment to Social Justice*, which is scheduled for 9:00 AM on August 1st at the annual meeting of APA in Honolulu. She is also a co-author on three other papers being presented at the convention. Thank you to the members of the Award Subcommittee of the International Committee, John

Thoburn, Carl Auerbach, and Georgi Antar, who participated in the selection process.

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 send information to Dr. Elizabeth Carll, Chair, Division 56 International Committee, at ecarll@optonline.net.

Linh Phuong Luu, M.S., Recipient of the 2013 Division 56 Student Travel Award

To encourage participation of international students at the APA convention, Division 56 approved a \$500 International Student Award and complimentary convention registration to support travel. A free one year membership in Division 56 is also included. The recipient of the International Student Travel Award is Linh Luu, who is originally from Vietnam, and is a PhD student in counseling psychology at Lehigh University in Pennsylvania with a 4.0 GPA. Prior to attending graduate school, Linh Luu was a Junior Therapist, at the Vietnam National Hospital of Pediatrics in Hanoi, where she administered assessments and performed behavioral intervention for

APA Fellows Committee Workshop

The APA Fellows Committee workshop "Applying for Fellowship—An Overview from the Fellows Committee" will take place on Friday, August 2, from 10:00 to 10:50 a.m. at the Honolulu Convention Center in Room 307B, and is open to anyone interested in becoming an APA Fellow. In this workshop, members of the APA Fellows Committee will provide advice on how applicants can build a strong case for Fellowship. It will also provide an opportunity for aspiring Fellows (including early career psychologists) and divisional committee members to ask questions and better understand how to present evidence that they meet the criteria for Fellowship.

Graduate Training and Trauma: The Need for Treatment Flexibility and Creativity

Robert S. Cavera, M.S.

Incidents of traumatic events ranging from natural disasters to interpersonal violence that put individuals at high risk for developing posttraumatic stress disorder (PTSD) symptoms are pervasive in our society (Buka, Stichick, Birdthistle, & Earls, 2001). While there is a clear need to deliver efficacious treatment aimed at reducing symptoms of PTSD, the following case study from my graduate student internship illustrates how trauma treatment must also be creative and flexible.

When I began my clinical training at the Child and Family Trauma Institute in the Joan and Arnold Saltzman Community Services Center in Hempstead, New York, I planned to use the evidence-based, manualized treatment procedure described in Foa, Hembree and Rothbaum's (2007) *Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experience*. This model calls for psychoeducation of trauma and hierarchical exposure over the course of 10 to 15 sessions. In preparation for my first session with Alex W.*, I read the manual several times to completely familiarize myself with the treatment protocol.

The client was the victim of a shooting incident in which police officers in the vicinity of his house exchanged gunfire with a man armed with a shotgun. Several dozen bullets strayed into the living room of the client's house as Alex, his wife and six children (ages four to 18) occupied it. Although no one was physically hurt, many of the family members suffered from psychological distress, with the client reporting the most intense and persistent symptoms, including hypervigilance, reactivity to loud and unexpected noises, and thoughts of retribution towards the perpetrators. He also suffered from vivid and debilitating nightmares during which he would re-experience the shooting.

As treatment commenced, it became apparent that the client's nightmares were his most distressing symptom. Although nightmares are not commonly the focus of cognitive behavioral therapy for trauma

(Montangero, 2009), the decision was made to adapt the manualized treatment to focus on his traumatic nightmares with exposure an important underlying "active ingredient" as in many efficacious behavior-oriented trauma therapies (Wampold, 2001). The client was taught relaxation techniques and, during therapy,

was asked to describe his nightmares in vivid detail, including the sights and sounds of the event as well as the visions of his family as they reacted in horror to the event as it unfolded.

As this case shows, the treatment of trauma is in many ways paradoxical. The treatments with most empirical support involve some degree of re-exposure to the traumatic event, usually through in-vivo (first hand) or imaginary (through visual imagery) processes (Foa, Hembree & Rothbaum, 2007; Foa & Rothbaum, 1998). However, since the therapy essentially forces the client to talk about or confront the trauma, he or she may become treatment avoidant and not attend therapy consistently. After three sessions, Alex became overwhelmed by the idea of therapy

near the clinic and refused to leave his car and enter the building. Therapy was conducted in the parking lot that particular evening, acknowledging the fact that he was able to make the trip in the first place. As that session neared completion, aside from the positive reinforcement he received, Alex was offered the opportunity to continue therapy in a similar format (e.g., in the parking lot, on a bench near the clinic), if he felt that was within his capability. He was also reminded that he had reached a difficult stage in treatment and was encouraged to continue. Several relaxation strategies (e.g., deep breathing exercises) were also reviewed in preparation for his next session the following week.

Once Alex was able to recognize that the therapist would not proceed at a pace that would be overwhelming for him, Alex responded to the modified exposure techniques, (i.e., gradual confrontation with the negative stimuli). At session 10, his traumatic nightmares decreased from nightly and a rating of "10" on the Subjective Units of Distress Scale (see Cavera, Jacobs & Motta, *in press*, for sample created specifically for this case) to nonexistent. His sleep quality also increased as evidenced by scores on the Pittsburgh Sleep Quality Index (Buysse, Reynolds, Monk, Berman, & Kupfer, 1987). Treatment gains were maintained at one, three, and six-month follow-ups (see Cavera, Jacobs &



Robert S. Cavera, M.S.

* A pseudonym.

Motta, *in press*, for a comprehensive description of this case study).

However, once the PTSD symptoms began to subside, a bevy of other problems emerged for Alex. Even after his traumatic nightmares had abated, his suffering continued. The home environment of his large family, which had been chaotic prior to the traumatic event, increased exponentially afterward. The client had a great deal of anger about the way his wife and children acted towards him as well as his tenuous relationship with his mother. This put a significant strain on his marriage and his relationship with his children and mother.

The need for treatment flexibility continued to be apparent and Alex was seen along with his wife for couples therapy, while many of his children were treated by individual therapists. After a year and a half of therapy focusing on trauma-related symptoms (including anger and depression), as well as marital/family issues, he reported significant global symptom reduction as well as healthy and positive relationships with his wife and children.

The lesson learned from working with this client is that there is no such thing as “simple” trauma. Even when not in a developmental context, trauma is a complex, multifaceted disorder. It not only affects the individual, but also those closest to them. When one member of a family experiences a trauma, the impact on the family unit can be profound. The insidious nature of trauma is not always visible upon first meeting a person. In the case of Alex, his personal relationships and work output suffered as well as his overall quality of life. None of these topics became evident until several sessions into treatment.

These experiences among others in the past two years of my clinical training have altered the way I now conceptualize trauma and its treatment. Important lessons can be learned from the differential relationship between research and practice. The protocols that researchers propose for treatment and what clinicians find most useful in treating trauma may not be the same. Treatment that is research-based is often considered the “gold standard” for treating anxiety (Deacon & Abramowitz, 2004), and especially effective for psychological trauma (McLean & Foa, 2011). However, following strict treatment protocols is extremely difficult due to the complex nature of these issues. My work as a graduate student in training has shown me that the creativity and flexibility a therapist employs in treatment seems significant for providing a personalized treatment program.

Learning to work effectively with this population in reality is a challenging yet satisfying endeavor—with client improvement and growth serving as the ultimate reward.

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Robert S. Cavera, M.S., is a third-year doctoral student in the School-Community Psychology Program at Hofstra University. His clinical and research interests focus on assessing and treating posttraumatic stress disorder in community populations.

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.

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

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

Who's Who:

Beverly Ann Dexter, Ph.D.

Nina K. Kominiak, B.S.

U.S. Navy Commander (Ret.), **Dr. Beverly Ann Dexter** is a warfare-qualified former U.S. Special Operations Officer (diver and ship driver) and former U.S. Navy Supply Corps Officer. She has served operational tours as a psychologist on four Navy ships and on Marine Corps bases. Dr. Dexter knows military life not only as an active duty soldier but also as part of an active duty couple, a military wife, and mother. She has been stationed overseas and served in a combat zone.



Beverly Ann Dexter, Ph.D.

Dr. Dexter is also the Founder and Chairman of the Military Special Interest Groups for both the International Society for Traumatic Stress Studies, and EMDR International Association, two of the most important trauma professional organizations in the world. A decade ago, Dr. Dexter developed a theory called Planned Dream Intervention and has taught this intervention to more than 30,000 people.

Dr. Dexter says she loves her job so much that it doesn't feel like job. So let's find out who she is, and what gives her the never-ending energy and enthusiasm to help clients with traumatic experiences.

1) What is your current occupation?

I am a contracted psychologist providing services for the Preservation of The Force and Family (POTFF) program in support of the 1st Special Operations Wing under the Air Force Special Operations Command at a Florida Air Force Base. My tasks include resilience building, individual, couple and family therapies, conflict resolution training, and helping military families to have happier lives.

2) Where were you educated?

I earned my PhD in Psychology at California School of Professional Psychology in San Diego and my

undergraduate degree is from University of Kansas. I have also studied at San Jose State University.

3) Why did you choose this field?

I have served in the Navy for 28 years—20 years in Active Duty and eight in the Reserves. I started as a diving and salvage officer, later transferring to the Navy Supply Corps. I left the Navy to complete my PhD, and returned back to the service as a psychologist.



Nina K. Kominiak, B.S.

Both my husband and I were active duty officers when we were married 25 years ago, and we knew that both of us couldn't be doing the same job. Being frequently out

on deployments and participating in military operations all over the world wouldn't have been an option with children. I had learned about psychology from a Scottish psychologist who would come to our ship, which was homeported in Scotland, and I eventually ended up in the field.

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

Restoring people to a healthy life and turning things upside down in a positive way!

Military families have more than enough trauma experiences. Prolonged and frequent deployments take their toll on families, leading to relationship difficulties that are unfortunately seen in increased divorce rates. Also, in many cases, suicides and depression are not related to the combat experiences but rather to disrupted, broken relationships that drive individuals to desperate actions.

I am privileged to help clients with their trauma experiences. With my extensive training and experience in the field I am able to help them make life-changing differences.

5) What is most frustrating about your work?

There are a lot more clients than we have resources! I wish we had more professionals in the trauma psychology field; even occasional pro bono work would be highly appreciated among the military service members and their families.

Also, it would be wonderful if psychologists working side by side with service members had some first-hand military experience. While a psychologist who has never been involved in the military can do a tremendous job with military clients, the learning curve to understand the culture can be very steep. There is a serious need for qualified trauma psychologists, and at the same time this is a very specific, demanding field. It would be beneficial to have an APA Board certification for trauma therapy.

6) How do you keep your life in balance?

There is a saying, “if you love your work, you’ll never work a day in your life,” and I do love my job! I also enjoy reading and long-distance running, and have completed 17 marathons over the years. Now, instead of competing, I run to stay healthy and have fun.

The single greatest balancing element in my life is my family: a loving husband and three most amazing daughters. Our daughters have adjusted extremely well to the military lifestyle and frequent moves, and they

have grown into wonderful young ladies.

7) What are your plans for the future?

Over a decade ago, I had some unusual experiences that were followed by frequent nightmares. One night a year later, the nightmares stopped and I understood how it had happened. Consequently, I wrote a book titled *No More Nightmares: How to Use Planned Dream Intervention to End Nightmares*.

My life goal is to work on Planned Dream Intervention full-time, and teach it worldwide. I would love to travel to African countries such as Uganda and Rwanda, to help people in war-torn corners of the world learn how to sleep peacefully and enjoy improved health and happiness.

Nina K. Kominiak, B.S., has been working in the technology field for over a decade, holding positions in the U.S. as well as overseas, and is preparing for graduate studies in Cognitive Neuroscience. She is currently doing research on Military Spouses’ Perception on PTSD and Depression, as well as Conditioned Place Preference studies about substance abuse. She also volunteers in various military organizations, and is a board member and Disaster Response Network coordinator for the Alaska Psychological Association, AK-PA.

Apply for Fellow Status

We invite 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 to apply.

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. You can find everything you need to know about applying for Fellow Status at: <http://www.apa.org/membership/Fellows/index.aspx>

In addition to meeting the APA criteria, applicants applying for Fellowship status within Division 56 must meet Division 56 criteria, which are 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 to 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 web site 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 web site at <http://www.apatraumadivision.org/honors.php>).

Please submit these materials by e-mail to Laurie Pearlman at: lpearlmanphd@comcast.net. We accept 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! And if you know a Division 56 member whose work meets these criteria, please feel free to encourage that person to apply!

Levine, P. A. (2010). *In an unspoken voice: How the body releases trauma and restores goodness*. Berkeley, CA: North Atlantic Press.

Anne C. Pratt, Ph.D.

In *An Unspoken Voice: How the Body Releases Trauma and Restores Goodness* is Peter Levine's seminal book on Somatic Experiencing (SE), which is his treatment for trauma, based on the common thread among the trauma responses of a wide variety of species. Levine, who holds doctorates in both medical biophysics and psychology, has authored or co-authored six books based on this treatment approach; this book provides the basics of the theory. Divided into four parts, the book provides: the roots of the theory, case examples, the historical evolution of our understanding of our animal nature, and, finally, a description of the relationship of the body to emotion and the spiritual nature of healing from trauma.



Anne C. Pratt, Ph.D.

Early in his career, Levine wondered why animals could repeatedly experience life-threatening trauma yet continue to function normally whereas many people suffer for years after a traumatic event. SE is based on 40 years of his study and practice, as well as ethological studies, cross-cultural research, evolutionary psychology, extensive neurobiological research, and decades of clinical experience.

In Levine's theory, when a traumatizing event occurs, the animal (or human) has a foreseeable physiological response. Across species, the fight-flight-or-freeze response is activated, and the organism responds with a predictable pattern of hormonal, muscular, and brain behavior. Decision-making about whether to fight, flee, or freeze occurs in the brainstem, not the cerebrum. The body prepares for action, and, if action is impossible, goes into freeze mode like a deer in the headlights or a

possum playing dead. In fact, animal paralysis has no element of play or intention; the possum experiences "tonic immobility," a phenomenon well documented in the literature.

Animals slowly come out of the fight-flight-freeze response with a period of inactivity followed by shaking or trembling. Levine posits that this is what is missing in the usual human response to trauma; instead we keep the body braced for action. "When acutely threatened, we mobilize vast energies to protect and defend ourselves. We duck, dodge, twist, stiffen, and retract. Our muscles contract to fight or flee. However, if our actions are ineffective, we freeze or collapse" (Levine, 2010, p. 23).

SE helps the individual transform the frozen, fearful states by teaching awareness of the sensations and how to slowly, safely, and gently tolerate these feelings.

Learning to live through states of high arousal...allows us to maintain equilibrium and sanity... When, on the other hand, these 'discharges' are inhibited or otherwise resisted and prevented from completion, our natural rebounding abilities get 'stuck.' Being stuck, after an actual or perceived threat, means that one is likely to be traumatized or, at least, to find that one's resilience and sense of [wellbeing] has been diminished (Levine, 2010, p. 17).

Fear and immobility feed each other, creating a vicious cycle. Thus, in SE, it is considered crucial to gradually access the bodily reactions to avoid overwhelming or retraumatizing the client. It is not a therapy based on exposure or reliving, but instead creates a sense of safety and teaches the client to become mindful of physiological states, develop curiosity about those states, and slowly approach the hyperarousal connected to the memory of the traumatic event. The therapist supports the client in accessing and observing

these responses and then by allowing completion through (often subtle) trembling and other forms of discharge.

In an Unspoken Voice includes a clear and understandable explanation of SE, highly detailed case examples, and a wide-ranging description of the research that led to the development of the theory. Levine offers coherent explanations of the workings of the sympathetic and parasympathetic nervous systems, for example, or the threat response in humans and other animals. He invites us to follow him as his research informs his thinking, and as his clinical work deepens his understanding of the role of the body in trauma response.

The case examples illustrate problems such as those of Miriam, who lost her first husband suddenly many years before and is struggling in her current marriage, and Adam, a Holocaust survivor. Details of therapy sessions are given with Levine tracking gestures, breathing, heart rate (observing the carotid artery), and trembling, as well as words. He continually redirects clients to help them observe physical sensations, which reduces anxiety (or panic) and gradually adds a sense of strength and confidence. This sense of strength allows them to experience their physical sensations more deeply, often bringing up memories. Levine guides the clients to continue focusing on the body, avoiding “premature cognition” and allowing the trauma response (such as involuntary trembling) to occur.

The cases are explained in relation to the theory both at the level of moment-to-moment detail and broadly so that the reader can really see the theory in action. Levine explicitly contrasts SE with exposure-based therapies.

One of the pitfalls of various trauma therapies has been their focus on the reliving of traumatic memories along with intense abreaction of emotions. In these exposure-based treatments, patients are prodded into the dredging up of painful traumatic memories and abreacting emotions associated with these memories, specifically those of fear, terror, anger and grief (Levine, 2010, p. 184).

While many may object to this characterization of exposure-based treatment, Levine does draw a distinct difference in both the theory and the process of therapy.

Our field has been evolving toward a focus on the body – the central nervous system – for decades. With Bessel van der Kolk’s publication of *Post Traumatic Stress Disorder: Psychological and Biological Sequelae* (1984) and of the seminal article, “The Body Keeps the Score: Memory and the Emerging Psychobiology of Post Traumatic Stress” (1994), the physiological aspects

of trauma fully entered the mainstream. Pushing the limits of the scientifically accepted therapies of the day, he began working with Eye Movement Desensitization and Reprocessing (EMDR), and recently wrote the introduction to Emerson and Hopper’s *Overcoming Trauma through Yoga: Reclaiming Your Body* (2011), to which Levine wrote the foreword.

In a similar vein, many other researchers and clinicians have emphasized the connection between trauma and illness (e.g. MacFarlane, 2010; Felitti & Anda, 2010), and recent contributions by Stephen Porges (2011), for example, shine light on the neurobiology of social interactions.

Among his works, Levine has co-authored several self-help books, most recently *Freedom from Pain: Discover your Body’s Power to Overcome Physical Pain* (Levine & Phillips, 2012). It can be instructive to therapists in treating chronic pain with SE, and likely helpful to their clients. However, it is not clear how an approach that relies so much on the therapeutic relationship will fare as a self-help method.

As quickly as we move toward a focus on evidence-based practices for treating trauma, multiple alternative treatments seem to appear. Evidence for the effectiveness of these alternative treatments may be sparse or missing, but many are embraced by therapists whose clients bring a sense of urgency and desperation to treatment. Initial enthusiasm may be infectious, and the experimenting therapist might get positive feedback from clients, even if the technique is inexplicable, theory-free, and untested. Some of the alternative therapies will grow up to become well-articulated, carefully-studied, and prized as effective evidence-based treatments. Others will fade from view, appropriately.

Will SE break away from the class of alternative treatments and become part of the mainstream? Research on the efficacy of this therapy is in its infancy. Until Levine and his many colleagues begin to conduct and publish controlled research, SE will remain an intriguing contender. I, for one, eagerly await the results of that research.

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Anne C. Pratt, Ph.D., is a clinical and forensic psychologist in Massachusetts who has worked with traumatized individuals for 25 years. She works at Family Care Medical Center in Springfield and Forensic

Services in Northampton. Previously, she has worked in state hospitals, jails, private practice, and at the Traumatic Stress Institute in South Windsor, Conn. She has a particular interest in assessment of trauma response in people with criminal charges and people involved in civil litigation.

Integrating Emotional Trauma: Trauma Recovery Is an Oxymoron

Robert D. Stolorow, Ph.D.

Two central, interweaving themes have crystallized in the course of my ongoing efforts to grasp the essence of emotional trauma. One pertains to trauma's context-embeddedness – painful emotional experiences become enduringly traumatic in the absence of a welcoming relational home or context of human understanding within which they can be held and integrated. The second theme pertains to trauma's existential significance—it plunges us into the devastating recognition that in virtue of our finitude and the finitude of all those we love, the possibility of emotional trauma constantly impends and is ever present. I have suggested that in the context of an understanding and holding relational home, traumatized states can cease to be traumatic, or at least cease to be as severely and enduringly so.



Robert D. Stolorow, Ph.D.

Now, however, I wish to add an existential qualifier to that last claim. Like its analogue, “secure attachment,” “trauma recovery” is an oxymoron—human finitude with its traumatizing impact is not an illness from which one can or should recover (Stolorow, 2011). A felt requirement to recover from or become immune to the circling back to emotional trauma can be a source of intense shame and self-loathing when, inevitably, it cannot be achieved. “Recovery” is a misnomer for the constitution of an expanded emotional world that

coexists alongside the absence of the one that has been shattered by trauma. The expanded world and the absent shattered world may be more or less integrated or dissociated depending on the degree to which the unbearable emotional pain evoked by the traumatic shattering has become integrated or remains dissociated defensively, which, in turn, depends on the extent to which such pain found a relational home in which it could be held. This is the essential fracturing at the heart of traumatic temporality and the dark foreboding that is its signature emotion.

Reference

Stolorow, R. D. (2011). *World, affectivity, trauma: Heidegger and post-Cartesian psychoanalysis*. New York: Routledge.

Robert D. Stolorow, Ph.D., is a Founding Faculty Member at the Institute of Contemporary Psychoanalysis, Los Angeles, and at the Institute for the Psychoanalytic Study of Subjectivity, New York City.

He is the author of *World, Affectivity, Trauma: Heidegger and Post-Cartesian Psychoanalysis* (Routledge, 2011) and *Trauma and Human Existence: Autobiographical, Psychoanalytic, and Philosophical Reflections* (Routledge, 2007) and coauthor of eight other books. He received his Ph.D. in Clinical Psychology from Harvard University in 1970 and his Ph.D. in Philosophy from the University of California at Riverside in 2007.

Hurricane Disaster: I Just Want My Life Back

Cheryl Sawyer, Ed.D., Eva “Dee” Sloan, Ph.D., and Rebekah Pender, Ph.D.

Each summer, residents of coastal communities prepare for the beginning of hurricane season. State, county, and city governments plan evacuation routes, civilian emergency

crews man rescue headquarters, and the Red Cross, Salvation Army, and local churches prepare to shelter evacuees.

For residents of Florida, the 2004 hurricane season forced this exercise four times in a period of two months. Even though preparation strategies were

reviewed, revised, and revamped based on information gained from 2004, the 2005 hurricane season introduced unprecedented evacuations, urban devastation, and resulting chaos in Mississippi, Louisiana, and extreme southeast Texas while Hurricane Ike submerged Galveston Island and Boliver Peninsula in 2008. Superstorm Sandy in 2012 ravaged the entire east coast of the United States and was closely followed by

weeks after the 2005 Katrina-Rita hurricane struck the upper Gulf Coast, a Houston area university organized a conference to help area care givers (clergy, social workers, school counselors, mental health professionals) regroup and prepare for the long process of helping the Houston area community and the New Orleans evacuees who sheltered in the Astrodome to heal. The keynote speaker, Dr. Bill Steele, Director of the Institute for



Cheryl Sawyer, Ed.D.



Eva "Dee" Sloan, Ph.D.



Rebekah Pender, Ph.D.

a massive snowstorm that continued to wreak havoc and cause damage to an already decimated coast line as well as inland homes and businesses. Most public service disaster organizations struggled to cope with the widespread physical and emotional damage wrought by any of these disasters. Public schools and social service providers were no exception.

Mental Health workers, therapists, counselors, and public servants in these affected areas may likely experience secondary trauma and compassion fatigue throughout the coming year. Any mental health crises present before the natural disasters will rage onward with fewer support resources than prior to the storms. Agencies and counselors who serve traumatized clients and students will most likely spend an equal amount of time with overly stressed and traumatized faculty and staff members who lived through the ordeal and are also expected to provide ongoing support for the community. Many of those impacted by the vast social, emotional, and material devastation will become increasingly demonstrative of the symptoms for Post-Traumatic Stress Disorder (PTSD) and other complicating factors. At some point, many people will ask themselves the question, "Am I losing it? Will I ever get my life back?"

The answer to these questions might be found in a review of the thoughts and perceptions of those who have experienced natural disasters in the past. Three

Trauma and Loss in Children, presented activities and strategies for counseling survivors of disaster. This presentation concluded with a mass trauma-debriefing for the care-givers in attendance, who were given the opportunity to offer their personal involvement, responses, and reactions to the ordeal. The following study synthesizes the questions and responses given by this group of care givers.

The question, "What were you NOT prepared for relating to the events associated with the Katrina and Rita hurricanes?" was posed by Dr. Steele to the group at large. The following phrases were included as part of the discussion as examples of situations that were stressful, unsettling or traumatic to care-givers:

- *Staring, stressed babies without parents*
- *The separation of children from their families*
- *Criminal activity and fear of physical harm, including stories of rape and sexual assault on children*
- *Graphic television newscasts showing dead bodies, massive devastation, helplessness and hopelessness*
- *Dysfunctional, disorganized government coupled with political blame games*
- *The deterioration of and injury to the skin and impact of water for those who had to wade or stand in flood waters*
- *Lack of effort on the part of many evacuees to help*

- themselves once they reached safety*
- Inability to reconnect families.*

In response to the next question posed by Dr. Steele, “What did you do or feel that surprised you?” discussion included the following observations:

- I eventually became detached and shut down. I could no longer feel compassion or empathy for those caught up in the ordeal.*
- I was crying when I was alone but I was able to stay composed when working with evacuees.*
- I'm angry that [school] “administration” expects us to go back to business as usual at our school, i.e. administration of standardized tests, enforcement of attendance policies, spelling tests, etc.*
- I was angry with myself for ...
being over-emotional,
for not being an effective resource,
for feeling fear,
for not staying focused on my client's experiences,
discounting the exhaustion levels of the evacuees
not pacing myself so that I didn't burn out too
not using my own support systems to relieve my own stress
for being over-structured and inflexible after my own evacuation
for putting my own needs ahead of those of my clients or family
overreacting to “little” things*
- I think I was somewhat angry that the storm didn't actually hit us; we went through that 28 hour evacuation for nothing. People's pets died for nothing. It is so absurd that I would even vaguely hope we got hit by the storm. I thought, “Come on, Rita” and almost wanted to get hit.*
- I can't believe I actually turned the Hurricane Rita evacuation trip into a vacation. There is so much guilt but I was relieved to have an excuse to get away from counseling Katrina evacuees.*

The next question posed to the respondents, “What worries you most about the events surrounding Katrina-Rita storms?” yielded the following responses:

- Lack of leadership on the local, state, and federal level leads me to believe that we're alone in taking care of ourselves.*
- Its been six weeks. We should have already “moved on” from Katrina and Rita by now and gotten on with our day to day life.*
- There are still so many displaced children that have no parents.*
- There is another month before hurricane season is over. It might happen again!*
- We have racial and cultural conflicts between the Katrina evacuees and local residents that pose new problems that we have never experienced before;*

there are no models to use as we try to join two very different cities into one community.

- Our resources are exhausted. There was not enough food, housing, money, services available to service our area before the storm; now we have an additional 250,000 people to serve and we were already overloaded.*
- Where are we going to find classrooms for all of these children? Who is going to counsel them? My caseload is already very high but I can't ignore the needs of either my local kids or the Katrina evacuees.*
- Our districts are still holding us accountable for the standardized test scores for these children. We don't know what they've learned and we don't know how we'll be able to meet mandated standards in time for the state assessments.*
- There is no model for us to follow. We are creating our own road as we struggle through this disaster. We're making mistakes and we don't even know it yet.*
- We feel guilty because we are so busy helping the Katrina evacuees that we are neglecting our “own” caseloads.*
- The economic impact of these storms is unimaginable. I don't see how we can recover and I don't see how we can make due with less (classroom space, gas, food, housing, support).*
- My compassion is wavering. So much death, so much destruction, so many horror stories, so many hurting families; I have a hard time listening to anyone's stories anymore and I find myself thinking, “Well, you didn't have it so bad” or “Just hurry up and get this story over with”.*
- I [counselor] can't talk to anyone about my own trauma because they have their own. My own traumatic experience is immobilizing me and there is no one for me to turn to release my own stress.*

The final question, “What have others done that have made a difference for you” yielded the following responses:

- Our employer gave us lists of what we would need to take with us, to pack, and what we might need when we got back home.*
- Our employer paid us in advance of the storm; we had money to use for the evacuation trip.*
- Our employer has promoted self-care and set up committees so that we can work as teams to help each other.*
- Families, churches, towns, across the state welcomed us with food, shelter, water, supplies, gas, and a safe place to rest. We gave to Katrina evacuees and, in turn, when we became evacuees ourselves, people gave to us.*
- People “stepped up” who have never volunteered or stepped up before. We helped ourselves.*
- This conference, and the opportunity to have a*

forum that validates what we've experienced as well as knowing that we have each other and this university as a resource for area care-givers.

Dr. Steele concluded by asking the participants to consider completing the following activities:

- *Write out your evacuation experience, in detail, in order to take it out of your head. Put your writing in a safe place and put your memories aside for now.*
- *Re-write the ending of your hurricane story so that you can imagine a positive outcome for this experience.*
- *Forgive yourself for being human, for being imperfect, and for judging yourself.*
- *Allow yourself time to recover from this ordeal. Acknowledge that it might take months before you feel energized again. Recognize that nightmares, exhaustion, startle-reactions, intrusive thoughts, low-level depression, and helpless feelings are often normal after a traumatic experience such as this but promise yourself that you will seek professional help if these PTSD related feelings continue beyond the next few weeks.*
- *Remember—It is not a weakness for a professional care-giver to seek help for themselves.*

The discussion that was then initiated by Dr. Steele proved to be a starting point for what counselors throughout the area would be experiencing and working with on a daily basis. He presented tasks and challenges counselors would most likely face after a disaster. Several years later, this same community was hit by Hurricane Ike. Although there were still significant issues and difficulties, many plans that were developed as result of the Katrina-Rita experience were implemented and during informal post-hurricane debriefing groups, local counselors described reduced trauma associated with Ike. Hurricane Sandy posed its own unique set of crises in communities that were unprepared for such devastation often because of the mentality “Oh, Hurricane Irene was a category I and that was no big deal.”


The learning curve addressing issues related to disaster and trauma support has been extensive in the past decade. Each disaster poses new, unique issues and complications; each requires creative, unique approaches toward resolving problems. The destruction and recovery after Hurricane Sandy specifically is still an on-going struggle for many who do not have their basic needs met yet some six months later. There is still uncertainty surrounding governmental assistance, insurance payouts, and sifting through the debris of

what might, if anything, be left behind. Emotional processing and healing cannot even begin until these concerns are resolved. However, based on information gathered both during and after these crises, researchers now are recognizing commonalities and redefining the concept of disaster “normal.” As each crisis dissipates, those who actually experienced and/or those who work with individuals who experienced the disasters find the energy, strength, and clarity to write and publish their findings. These publications can potentially help the next generation of disaster survivors to grasp the hope that “This too shall pass” and “normal” are just words that can be interpreted according to circumstances.

Cheryl Sawyer, Ed.D., Associate Professor of Counseling, is Coordinator of the Counseling Program at University of Houston Clear Lake and director of its federal bilingual counselor training project. She holds a M.A. in Behavioral Sciences and Ed.D. in Educational Leadership as well as Texas certification as Licensed Psychological Associate, Educational Diagnostician, School Counselor, and Licensed Specialist in School Psychology. Cheryl is certified as a Trauma and Loss School Supervisor from the National Institute of Trauma and Loss in Children. She serves on the Galveston County Child Services Board and is a patched member of Bikers Against Child Abuse.

Eva “Dee” Sloan, Ph.D., is an Assistant Professor of Counseling in the Counseling Program at the University of Houston Clear Lake and is Project Coordinator for the Bilingual Counselor Training Project underwritten by the Department of Education Office of English Language and Acquisition. She received her doctoral degree from St. Mary's University with concentrations in Play Therapy, Neurofeedback Therapy, and Rehabilitation Counseling. She also has worked with evacuees from Hurricanes Rita, Katrina, and Ike.

Rebekah Pender, Ph.D., is an Assistant Professor in the Counselor Education Department at Kean University. She earned her Ph.D. in Counselor Education and Supervision with concentrations in Play Therapy and Neurofeedback and is a Licensed Professional Counselor and National Certified Counselor. She has worked with children and adults ranging from her work in a juvenile detention center to working with those who have chronic mental illness in a Partial Hospitalization Program. Her experience also includes having worked with refugees and immigrants from around the world. A Hurricane Sandy survivor herself, Dr. Pender also worked with evacuees from Hurricanes Rita, Katrina, and Ike.



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Division of Trauma Psychology— Your Home in APA

The Division of Trauma Psychology of the American Psychological Association (APA) provides a forum for scientific research, professional and public education, and the exchange of collegial support for professional activities related to trauma and disaster in its scientific, professional, educational, and public policy aspects. The Division also helps to advance scientific inquiry, training, and professional practice in the area of trauma treatment and research as a means of furthering human welfare. We welcome all psychologists and other individuals in the mental health and other fields who have an interest in trauma psychology.

Why Join Division 56?

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

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

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

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

Member Benefits

- Members keep up-to-date on the latest developments in trauma psychology.
- E-newsletters with timely information on traumatic stress are delivered directly to your in-box.
- Member-only listserv provides on-going communication with other members and breaking news of trauma-related developments in APA.
- Voting privileges to elect representatives and participation in the Division's annual meetings.
- Eligibility to run for office, chair, and serve on Division committees and task forces.
- Our journal, *Psychological Trauma: Theory, Research, Practice, and Policy*, at the member rate of \$21.50 per year. You do not need to separately subscribe to receive this journal; just be sure that your dues are paid up and your mailing address is up-to-date.
- 30% discounts on Haworth/Taylor & Francis journals in the field of trauma. To receive these discounts, contact Haworth directly at 1-800-429-6784 (607-722-5857 outside the US/Canada) or order online and provide the code # TPD20.

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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.

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Authors' Submission Deadline	Issue	Publication Date
January 15	Winter	February
April 15	Spring/Summer	May
September 15	Fall	October

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