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DIVISION 56

TRAUMA PSYCHOLOGY

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NEWSLETTER

A View Inside

PRESIDENTIAL VOICE

Trauma Makes You Fat: Why Trauma Psychologists Should Be Part of the Discussion About the "Obesity Epidemic"

Kathleen Kendall-Tackett, PhD

January and February tend to be miserable months at my gym. That's when everyone who has made New Year's resolutions to "lose weight" or "get in shape" decides that they need to join a gym. They come for a month or two and then disappear for the rest of the year. This migration reflects only a small part of the American obsession with weight. And the weight-loss industry capitalizes on our obsession, raking in an estimated $59 billion dollars per year. Unfortunately, Americans continue to get heavier, even as we spend more money on diet and weight-loss products.

Kathleen Kendall-Tackett, PhD

Even the American Psychological Association has gotten into the act; at our 2012 annual meeting, obesity was a presidential theme. I attended most of the sessions on this topic and heard a lot about diet, behavior change, exercise, portion control, and eating more fruits and vegetables. The conclusions in the majority of sessions were pretty clear: Americans were fat because they were eating too much and exercising too little. So how could we convince them to mend their ways?

The problem is that obesity is much more complex than these sessions made it sound. The sessions also left out something important: trauma. I did not hear it mentioned even once, a significant omission. In fact, evidence now suggests that trauma, indeed, does make you fat.

For example, in a study of 4,641 middle-aged women, with a

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mean age of 52 years, a history of childhood physical or sexual abuse doubled the risk of both depression and obesity (Rohde et al., 2008). Similarly, a meta-analysis of 24 studies (N = 48,801) found that physical or sexual abuse in childhood increased the risk of metabolic disorders including diabetes and obesity (Wegman & Stetler, 2009). Although this association existed for both men and women in the study, it appeared to be stronger for women.

Perhaps one of the more convincing studies regarding the link between trauma and obesity was conducted using data from the Nurses' Health Study II (N = 73,418). In this study, the authors found that childhood sexual or physical abuse increased the risk of Type 2 diabetes, a disease often cited as being related to a higher BMI (Rich-Edwards et al., 2010). This association existed even after controlling for age, race, and body type at age 5, parental education, and parental history of diabetes. The more severe the abuse, the more severe the symptoms of diabetes. For women who experienced severe physical abuse, the risk of diabetes increased by 50%. For women who experienced repeated forced rape, diabetes risk increased by 69%. The body mass index (BMI) was also influenced by past abuse. Physically and sexually abused girls had higher BMIs than their non-abused counterparts, and they gained weight more rapidly. This was especially true for those who experienced repeated forced sex.

Another recent study used a sub-sample of this same data set (N = 54,224) and examined the impact of PTSD on weight (Kubzansky et al., 2013). The researchers found that PTSD symptoms increased the risk of being overweight or obese. In addition, PTSD altered BMI trajectories over time. The more PTSD symptoms the women had, the greater the increases in BMI.

Sleep Impairment as a Possible Mechanism

There are a number of plausible mechanisms that explain the link between trauma and weight. One of the key factors is the impact of trauma on sleep. Trauma survivors often have impaired sleep, including longer sleep latency (minutes to get to sleep), shorter sleep duration, more night awakenings, and greater daytime fatigue (Kendall-Tackett, Cong, & Hale, 2013). Sleep problems in turn have been found to increase the risk of obesity. In a meta-analysis of 36 studies (N=634,511), short sleep duration was related to obesity worldwide. This was true for both children and adults (Cappuccio et al., 2008). Even short periods of sleep deprivation can elevate cortisol and glucose levels, and increase insulin resistance (McEwen, 2003). In another study, short sleep duration was related to metabolic syndrome in middle-aged adults. Specifically, short sleep duration was related to abdominal obesity, elevated fasting glucose, and hypertriglyceridemia (Hall et al., 2008).

What these findings suggest is that people who experience chronic sleep problems are physiologically prone to gain weight and to gain weight in ways that impair their health (e.g., abdominal obesity). Insulin resistance is also particularly concerning as it is a hallmark syndrome of metabolic syndrome, a risk factor for cardiovascular disease and diabetes (Haffner & Taegtmeyer, 2003).

For many Americans, their BMI is likely to remain high until their trauma symptoms are addressed. This is not simply a matter of trauma survivors eating more (although that could be true in some cases). The more plausible argument is that trauma has changed their physiology, especially their sleep, and has made it more likely that they will gain weight. All the diet and exercise advice in the world will not alter this underlying problem. In short, if we want to do something about the "obesity epidemic," trauma needs to be part of the discussion. Until it is, our efforts are likely to fall far short of the mark.

The impact of trauma on health is the presidential theme for this year. Stay tuned for more on this topic. If we truly want to improve the health of Americans, we must address trauma.

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Changes at *Trauma Psychology News*

Renu Aldrich, MA, MFTi

Tyson Bailey, PsyD

Jodi Bremer-Landau, MA

Dear Colleagues,

It is my pleasure to begin serving as editor-in-chief of *Trauma Psychology News* with this issue. In its eighth year since Topher Collier, PsyD, launched the publication, TPN has continued to grow and expand under the esteemed leadership of previous editors Ruth Blizard, PhD, and Simon Rego, PsyD, both of whom thankfully remain on the team as consulting editors. I would also like to recognize Valentina Stoycheva, PhD, and Sherrie Wilcox, PhD, for their continued excellent work as our co-Chief Editorial Assistants.

Please welcome the new additions to the TPN editorial team: Associate Editor Tyson Bailey, PsyD, and Assistant Editor Jodi Bremer-Landau, MA. Tyson is an Early Career Psychologist in a trauma informed group psychotherapy practice. He is the web editor for Division 56 and also has served as ECP editor for TPN since 2011. Jodi is a counseling psychology doctoral candidate from Lehigh University with specialized interests in trauma, PTSD, substance abuse, and gender issues. She will also be starting an APA-accredited internship at Battle Creek VA Medical Center this summer.

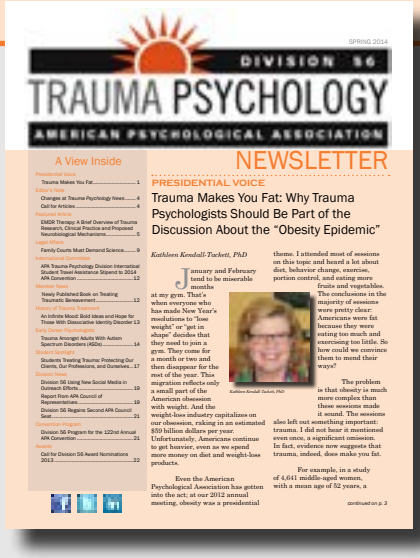
Among their duties, Tyson and Jodi will edit new columns that will launch over the next several issues including the history of trauma treatment, treatment and techniques, and international adventures in trauma training. We are also unveiling a new section on Member News for Division 56 members to showcase the latest developments in their careers, including book launches, presentations, awards, and fellowships.

As part of its mission to evolve with the needs of Division 56 and its members, TPN will be migrating to an online format and incorporating multimedia aspects. We will keep you apprised as these plans become reality. We welcome as many people who would like to become involved whether serving as department editors, columnists, or article authors. We also encourage feedback so please let us know how we are doing and what we can do to improve your experience with TPN.

Best wishes,
Renu Aldrich, MA, MFTi
Editor-in-Chief

Call for Articles

Trauma Psychology Newsletter is now accepting submissions for the Summer 2014 issue. All articles related to trauma psychology with a focus on theory, research, clinical or community applications, education and training, or policy will be considered. The deadline is June 1, 2014. Please limit length to 1,500-2,000 words, and send in MS Word or WordPerfect formats using APA Style. Please include a 100-word author bio at the end of the article and send a high quality photo (jpg or tiff) with your submission. Article submissions or requests for full editorial guidelines should be sent to both Editor-in-Chief Renu Aldrich, MA, MFTi, tpndiv56editor@gmail.com, and Associate Editor Tyson Bailey, PsyD, tdbaileypsyd@gmail.com.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Kathleen Kendall-Tackett, PhD

EMDR Therapy: A Brief Overview of Trauma Research, Clinical Practice and Proposed Neurobiological Mechanisms

Francine Shapiro, PhD

The publication of my first study (Shapiro, 1989) 25 years ago garnered much attention and controversy as the inclusion of sets of eye movements in the therapy understandably appeared strange. Unfortunately, this impression was reinforced by early randomized controlled trials (RCT) that were flawed by insufficient treatment doses, inadequate power, lack of fidelity, and/or inappropriate populations (see Chemtob, Tolin, van der Kolk & Pitman, 2000), causing misinformation about EMDR therapy to abound. However, since that time, more than two-dozen RCTs have supported the efficacy of EMDR therapy as a trauma treatment, and numerous RCTs have investigated the eye movements (http://www.emdrhap.org/content/what-is-emdr/research-findings/). A new meta-analysis of the eye movement research (Lee & Cuijpers, 2013) has demonstrated that this component does indeed play a role in the effectiveness of EMDR therapy. Further, practice guidelines recently released by the World Health Organization (WHO, 2013) have directly addressed the effectiveness of EMDR therapy as a whole and its divergence from trauma focused-cognitive behavior therapy (TF-CBT) procedures. Intriguing preliminary research has also indicated pronounced differences in therapeutic outcomes between EMDR therapy and CBT, suggesting different underlying neurobiological mechanisms.

Francine Shapiro, PhD

EMDR therapy is now established as empirically validated for the treatment of PTSD by a wide range of organizations, both domestically (e.g., DVA/DoD, 2010) and internationally (e.g., WHO, 2013). For instance, the new WHO (2013) *Guidelines for the Management of Conditions That Are Specifically Related to Stress* state that EMDR and TF-CBT are the only psychotherapies recommended for the treatment of posttraumatic stress disorder (PTSD) in children, adolescents and adults. Although both psychotherapies are recommended, the WHO (2013) guidelines describe the differences between the two treatments thusly:

> Like CBT with a trauma focus, EMDR aims to reduce subjective distress and strengthen adaptive cognitions related to the traumatic event. Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework (p. 1).

EMDR therapy is guided by the Adaptive Information Processing model (Shapiro, 2001, 2007, 2014), and consists of eight phases (see **Table 1**). These include standardized procedures for history-taking, client preparation, processing of (a) memories of adverse life experiences producing symptoms, (b) the current situations that trigger dysfunctional responses, (c) skills and behaviors needed for adaptive future functioning, and (d) evaluation of treatment outcomes. While CBT exposure therapies entail detailed descriptions of the disturbing event and extended concentration on the trauma during both treatment sessions and homework, EMDR therapy processing involves intermittent attention to disturbing information and an associative process that is stimulated during the sets of eye movements in the presence of the therapist. (For client session transcripts, see Shapiro, 2001, 2012, 2014). Since detailed descriptions of the event are unnecessary, EMDR therapy is amenable to trauma populations suffering from shame or guilt such as sexual abuse victims or combat veterans (e.g., Silver, Rogers & Russell, 2008). In addition, since homework is not needed, EMDR therapy is used by field teams of clinicians to treat victims of natural and manmade disasters with consecutive-day treatment or single extended sessions (e.g., 80-130 minutes; Jarero, Artigas & Luber, 2011).

In EMDR clinical practice, it is expected that single-trauma victims can be efficiently treated consistent with RCT reporting 84-90% remission of PTSD after 4.5 hours of treatment (Rothbaum, 1998; Wilson, Becker & Tinker, 1997) and 100% remission with a mean of 5.4 hours (Marcus, Marquis & Sakai, 2004). While the latter study also found a 77% remission of PTSD in multiple-trauma victims within the same timeframe, in clinical practice the treatment time for this population is generally expected to depend on several factors including: (a) the amount of preparation needed (e.g., if severely emotionally dysregulated), (b) the number of different "clusters" of adverse life experiences that must be addressed, and (c) the level of debilitation and skill deficit remediation required,

Table 1
Overview of Eight-Phase EMDR Therapy Treatment (25)

Phase	Purpose	Procedures
History taking	• Obtain background information. Identify suitability for EMDR treatment • Identify processing targets from events in client's life according to standardized three-pronged protocol	• Standard history taking questionnaires and diagnostic psychometrics • Review of selection criteria • Questions and techniques to identify (1) past events that have laid the groundwork for the pathology, (2) current triggers, and (3) future needs
Preparation	• Prepare appropriate clients for EMDR processing of targets	• Education regarding the symptom picture • Metaphors and techniques that foster stabilization and a sense of personal control
Assessment	• Access the target for EMDR processing by stimulating primary aspects of the memory	• Elicit the image, negative belief currently held, desired positive belief, current emotion, and physical sensation and baseline measures
Desensitization	• Process experiences toward an adaptive resolution (no distress)	• Standardized protocols incorporating eye movements (taps, or tones) that allow the spontaneous emergence of insights, emotions, physical sensations and other memories
Installation	• Increase connections to positive cognitive networks	• Enhance the validity of the desired positive belief and fully integrate the positive effects within the memory network
Body Scan	• Complete processing of any residual disturbance associated with the target	• Concentration on and processing of any residual physical sensations
Closure	• Ensure client stability at the completion of an EMDR session and between sessions	• Use of guided imagery or self control techniques if needed • Briefing regarding expectations and behavioral reports between sessions
Reassessment	• Ensure maintenance of therapeutic outcomes and stability of client	• Evaluation of treatment effects • Evaluation of integration within larger social system

Reprinted from Shapiro, F. (2012). *EMDR therapy training manual.* Watsonville, CA: EMDR Institute

particularly in instances of pervasive developmental trauma (Shapiro, 2001, 2014).

As an integrative psychotherapy approach, EMDR is compatible with diverse theoretical orientations (Shapiro & Laliotis, 2011); for example, it can enable clinicians to remediate relational difficulties by using selective processing to overcome impasses in the practice of family therapy (Shapiro, Kaslow & Maxfield, 2007).

The recent meta-analysis by Lee and Cuijpers (2013), published in the *Journal of Behavior Therapy and Experimental Psychiatry,* examined RCT that compared eye movements to an exposure condition while concentrating on a disturbing memory. Pre/post differences for both conditions were evaluated, including declines in standardized outcome measures, negative emotions, and imagery vividness. The authors reported statistically significant effect sizes that were moderate for the additional value of the eye movements in 14 clinical trials and large in 10 laboratory studies evaluating the eye movements in isolation. These findings indicate that the eye movements used in EMDR therapy contribute to the positive treatment effects and the processing of emotional memories. Research-supported explanations for the effects of the eye movements are that they (a) tax working memory, (b) elicit an orienting response, and (c) link into the same processes that occur during rapid eye movement

sleep (Kuiken, Chudleigh, & Racher, 2010; Lee & Cuijpers, 2013; Stickgold, 2002). All three mechanisms are posited to come into play at different times in the therapy process.

Some have argued that the primary component of the EMDR memory processing procedures is exposure. However, as indicated in the WHO practice guidelines, EMDR therapy does not entail the extended exposures used in CBT. While some RCTs have reported that EMDR therapy is more rapid and/or superior to CBT exposure therapy on some measures (e.g., Power et al., 2002), meta-analyses have reported comparable effect sizes (e.g., Bradley et al., 2005) despite the lack of exposure homework in the EMDR condition. The one rigorous RCT (Taylor et al., 2003), which reported that the exposure condition fared better on some measures, utilized four sessions of imaginal exposure, four sessions of therapist-assisted in vivo exposure, and one hour of daily homework (56 prescribed homework hours total). In contrast, the EMDR therapy condition used only eight standard sessions. As indicated by Rothbaum and colleagues (2005) regarding the results of their RCT, "An interesting potential clinical implication is that EMDR seemed to do equally well in the main despite less exposure and no homework. It will be important for future research to explore these issues" (p. 614).

EMDR therapy is now established as empirically validated for the treatment of PTSD by a wide range of organizations, both domestically and internationally.

The preceding findings underscore the need to examine the actual procedures used in EMDR therapy as compared to those of traditional exposure-based CBT. Importantly, research has indicated that the long exposures that characterize CBT cause *extinction* while the short exposures as used in EMDR therapy cause memory *reconsolidation* (Suzuki et al., 2004). This posited difference has important clinical implications. As described by Craske, Herman and Vansteenwegen (2006), ". . . recent work on extinction and reinstatement . . . suggests that extinction does not eliminate or replace previous associations, but rather results in new learning that competes with the old information" (p. 6). On the other hand, the reconsolidation implicated in EMDR therapy is believed to cause the original memory to be changed and stored in an altered form after treatment. The fact that exposure therapies are posited to leave the original trauma memory intact may explain why some favorable clinical outcomes have been achieved with EMDR that have not been reported with CBT treatment. One example is based on the observation that childhood trauma is associated with psychotic symptoms (Arseneault et al., 2011). A recent open trial (van den Berg & van den Gaag, 2012) reported that six sessions of EMDR trauma processing with psychotic patients resolved PTSD in 77% of the patients and had "a positive effect on auditory verbal hallucinations, delusions, anxiety symptoms, depression symptoms, and self-esteem" (p. 664). The majority of patients initially suffering from auditory hallucinations reported their disappearance by the end of the EMDR treatment. The researchers stated that this result has not been found with CBT treatment; in contrast, the patients treated with CBT generally continued to report auditory hallucinations, but experienced less distress.

These findings are consistent with other clinical outcomes reported with EMDR therapy:

(a) Processing of the memory of the traumatic event that resulted in limb amputation has been reported to cause a substantial reduction or complete elimination of phantom limb pain (e.g., de Roos et al., 2010).

(b) A mean of six sessions of EMDR therapy with a subset of child molesters directed at the memory of their own victimization resulted in significant changes, including substantial decreases of deviant arousal as measured by penile plethysmography, that were maintained at one-year follow-up (Ricci, Clayton & Shapiro, 2006).

(c) As compared to an exposure treatment, EMDR therapy processing of memories of traumatic loss resulted in twice the amount of positive recall of the deceased (Sprang, 2006).

Comparable results have not been reported with CBT treatment (e.g., Ray & Zbik, 2001). The reason may be that, as previously indicated, exposure-based treatment leaves the original trauma memory intact. The Adaptive Information Process model (Shapiro, 2001, 2007, 2014; Solomon & Shapiro, 2008) that guides EMDR therapy conceptualizes the unprocessed memory as encoded with the emotions, perspectives, and physical sensations that occurred at the time of the traumatic event. During processing, clients report changes in emotions and physical reactions, along with new insights, as the memory arrives at an adaptive resolution. As processing occurs, the episodic memory is posited to become integrated and stored within existing semantic networks without the dysfunctional beliefs, emotions, and physical sensations (Shapiro, 2001; Stickgold, 2002). The original unprocessed memory no longer is stored in the brain, accounting for the elimination of phantom limb pain and deviant arousal, as well as easy access to positive memories of the

deceased. If the original trauma memory remains intact after CBT exposure treatments, it would account for the continued pain, arousal, and interference with positive recall. The posited differences between extinction and reconsolidation and their implications for treatment represent an important subject for future rigorous research.

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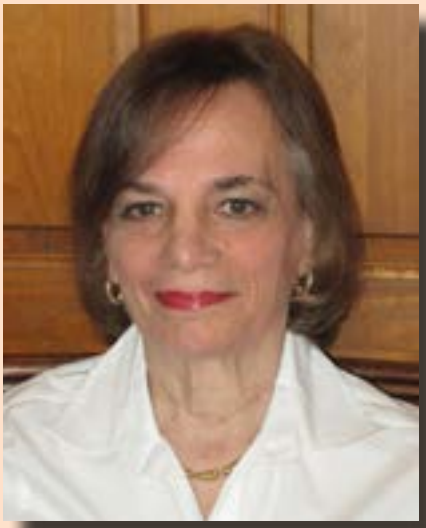
Francine Shapiro, PhD *is the originator and developer of EMDR therapy. She is a Senior Research Fellow Emeritus at the Mental Research Institute in Palo Alto, California, Director of the EMDR Institute, and founder of the non-profit EMDR Humanitarian Assistance Programs, which provides pro bono training and treatment to underserved populations worldwide (www.emdrhap.org). Dr. Shapiro is a recipient of the International Sigmund Freud Award for Psychotherapy, presented by the City of Vienna in conjunction with the World Council for Psychotherapy, the American Psychological Association Trauma Psychology Division Award for Outstanding Contributions to Practice in Trauma Psychology, and the Distinguished Scientific Achievement in Psychology Award, from the California Psychological Association. She has authored numerous publications about EMDR therapy, including the primary text for clinicians, Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures.*

Family Courts Must Demand Science

Toby G. Kleinman, Esq.

Family courts have the power to keep parents who harm their own children from parenting those children. Indeed, the family court is supposed to weigh in favor of child protection even over the right to parent. The judge is required to act *parens patriae,* essentially as the child's super parent. When cases are presented in court, rules and statutes require that expert testimony, upon which the judge will rely, be reliable and scientifically based.



Toby G. Kleinman, Esq.

In my experience, sadly, despite these requirements and the available remedies for protection, states fail the test of assuring that experts testify based upon what is accepted practice within the scientific community when they are in family court. As a result, aggressive protection of children is bypassed and children are too often placed in harm's way.

The science of child abuse is permitted to be ignored as many judges are not even properly trained to know when there is objectionable unscientific testimony. Lawyers are not required to promote science or have unscientific testimony precluded. Many, if not most, states permit a relaxation of rules for children's best interests, which allows—indeed almost asks for—unscientific testimony and the permitting of speculation by experts rather than the presentation of science. Often orders are entered long before trials, do not protect children, and are based upon judges' perceptions of facts as opposed to having testimony taken from knowledgeable professionals.

When testimony is taken at an early stage, family courts may permit testimony from unqualified and improperly trained or untrained experts. Too often these individuals promote unacceptable/unscientific practices and demand proofs of abuse that may be impossible and/or not scientifically necessary to affirm abuse.

We must begin to demand science from our experts in family courts. Testing and clinical data must be accepted within the family court and be reproducible in accord with accepted practice in the scientific community. Clinical judgments and overall recommendations must be based upon accepted practice in the community that is well versed in the science of abuse.

Family courts are affected by what is commonly accepted in society. There is an inherent disbelief in society as to children's unreliability as reporters. It seems to be assumed that children overstate things that happen to them. This social belief contradicts vast amount of research which says that children do not generally lie about abuse.

Judges and many others all too frequently automatically suspect the veracity of children who report abuse, especially when the named abuser is a parent and most especially where the parents are in the middle of divorce. Yet, it is not uncommon for children to report abuse in a circumstance where they feel safe and protected. So it follows that this would occur on the heels of a parental separation. Yet, when a newly separated parent reports a child's disclosure of abuse, the focus of a family court investigation tends to gravitate to an inquisition of the reporting parent's motives, reactions, and feelings rather than a child-focused protective response. This is in itself unscientific.

When the issue of abuse goes to family court, these and other risks predominate. The abuse takes a back seat to the attack on the person who brought it to a court's attention. If this information went instead to a criminal court, the trained investigators and prosecutors have no alternate investigation or evaluation except that of the child. Thus, criminal prosecution demands science. Family court must do it as well.

Sadly, when the matter is first reported to a family court, we are in a circumstance where the reporter, most often a mother, is not only disbelieved by a court, but she becomes the focus of the investigation. The mother tends to naively report what the child has disclosed to her and anticipates that her child will be believed and protected. Instead, she finds herself in the center of attack. Rather than granting the child protection, the court does not accept the mother's reports of the child's words. Sometimes a forensic evaluator is assigned to evaluate all of the parties in the divorce action, rather than appoint a specially trained evaluator to assess only with regard to the issue of abuse.

At this very first step in family court, any future potential for a criminal investigation may be tainted such that it would make future prosecution impossible, in part because an evaluation of child abuse does not require evaluating the named perpetrator. See APSAC

Practice Guidelines (American Professional Society on the Abuse of Children, 2012). But it is at this stage that a court should carefully protect the interests of a potential future prosecution.

When a custody evaluation is performed, rather than an abuse-specific evaluation, the focus is on the parents rather than on the allegations made by the child. In one typical scenario, the father denies abusing the child and accuses the mother of beingF overly angry at him; he alleges that the mother created a "story," coached the child and that she is seeking to interfere with his wonderful relationship with the child. All too frequently, the court orders the mother not to discuss the child's allegations with the child. The child, who trusted the mother enough to disclose, has his trusted parent essentially removed as a confidant.

In other areas of law, such as murder, we demand science be utilized. Why in the area of family law is it permissible to ignore science?

In that scenario, the father likely continues seeing the child. It is possible the judge has ordered supervised visitation for the father. In that circumstance, there is a negative message to reporter and to the child. The mother who reported feels unsupported while the father, the named abuser, likely feels believed and empowered. The child, who loves the father despite the abuse, may feel safe with a supervisor present and not disclose again. In this scenario, it is even more imperative that an expert understand the science of disclosure and behavior of an abused child. An abused child may have been threatened. An abused child may fear a parent going to jail and feel responsible. Science is critical.

Another scenario involves a named perpetrator being admonished by the court not to abuse and nothing is done to intervene with regular visitation. This "set up" by the court is ludicrous and sadly portends what follows. Sex abuse of a child by a parent in the middle of divorce may be the only crime where we ask a potential criminal if he committed the crime and rely upon his denial. It may also be the only crime other than rape where we assume the victim is lying. Indeed, an abusive parent actually lives in a circumstance where his behavior can be repeated at will much like a career criminal who continues to "get away" with it. Would a court consider telling a career criminal to "knock it off" while an allegation is pending? But in child abuse cases, as in domestic violence between spouses, courts tell abusers to stop abusing and actually rely upon their admonition not to abuse as if they really have that power. That admonition may be heard by the child molester as saying to the parent who reported the abuse as, "Liar liar! We don't believe you. This will be impossible to prove so you better give it up now."

Indeed, if anyone really believed a child was being molested, the molester would not be allowed to see the child. The assumption is that the father is right. The child's words are not at the forefront. The child's words get lost and are reported as if they were the mother's. The father deflects and says things like, "I would never abuse" or "I would never do such a thing and mother has always had a problem with sex" (as if child rape and molestation is the equivalent of adult sex); or "I don't understand why the child (or mother) would say such a thing."

In my experience, frequently, when the perpetrator's words are examined carefully (and the web he has spun is unspun carefully), there is no actual denial of the abuse itself. In all of this, the father makes himself out to be a victim of mother's attacks as if she had a spurious motive. Even the evaluation of the child risks becoming focused on undoing the disclosures of the child, rather than learning about the abuse itself, the evaluator becomes preoccupied with trying to figure out why else they might be accusing a father of abuse. This would not happen if experts were required to have science-specific knowledge or if this case was being criminally prosecuted.

The child loses his veracity as a first-hand reporter of something that happened to him. The child is not seen as a victim or treated as a victim; his words are parsed. It reminds me of when rape victims were permitted to be attacked on the witness stand with regard to their sex lives, as if sex and rape are synonymous.

With the child, the court should require someone with specialized training in interviewing children suspected of abuse. The science is critical. An expert can explain the scientific basis for why the child has reported in the way he has—how the experience of abuse appeared through the eyes of the child. Instead, the case in court becomes a he said/she said, while the child's words are ignored. Thus, an evaluation in family court may make it virtually inevitable that there will not be a criminal prosecution even if abuse is found.

Why did this happen? In other areas of law, such as murder, we demand science be utilized. Why in the area of family law is it permissible to ignore science? I blame ignorant lawyers and an unbalanced system of finances between parents, and the protective parent

being essentially charged as if they were the "state"—the prosecution—to prove the case without the resources or knowledge of how to do so. It is also untrained judges and their having dockets too large to give proper time.

Science has come to know that a child of 5, 6, 7 or 8 reporting abuse does not have a hidden agenda, and uses age-appropriate language to describe whatever he or she does, feels and experiences. In the vernacular, children "tell it like it is." We know perpetrators do not admit crimes against children. We know perpetrators often have multiple victims and they should never be alone with children. See the Association for the Treatment of Sexual Abusers (2001) *Professional Code of Ethics*. We know it is the perpetrator of abuse of a child who threatens to harm the child or someone he loves and may mock the child, saying she won't be believed. We know children are confused by the abuse by a parent.

But once the report of abuse bypasses prosecution and goes to family court, the case gets twisted to focus on whether or not the mother gave a false report. The story told through the eyes of the child gets lost.

The country has read the very public and heartfelt story of the now adult Dylan Farrow (Kristof, 2014), who reported to her mother when she was a mere seven years old that she was being molested by her father. She is an adult now. And as an adult, she has openly and courageously used her own words to tell her story of childhood molestation. She expresses her pain and her fear as well as her own mother's support and love.

In some circles, I have heard Dylan Farrow attacked, because her mother elected not to seek prosecution. There, she is not heard in the voice she used to tell of her experiences and her pain. She is being attacked now as a liar as though as an adult she is still the victim of an angry mother. She is not treated as an adult woman telling something about her personal history. She is still being mistreated. As with many of these cases, facts get twisted and misused. I read that Woody Allen claims he took a lie detector test. According to Ms. Farrow, he did not take one done by police but rather he had someone he paid administer a test.

As with many of these cases, Mia Farrow was accused of being angry. I hope she was angry—livid even. Why wouldn't any mother be angry hearing that their child was molested, abused, raped, hurt or injured by their own father, a person who is supposed to be trusted in their lives? But a mother's anger is used to imply that she was angry before the child reported the abuse, and her anger caused her to make a false accusation.

In all child sexual abuse cases between parents that I have seen there is the dichotomy. The words and reality of the child become attacked and undermined as if they are the mother's allegations. Even now, so many years later Dylan Farrow seems almost anonymous in telling her story as though it is not her story at all. When science is replaced with emotion, children are not put first.

I call on all psychologists who care about children to demand science in their community, and when children report abuse to them or to a parent, that that they advocate for the child and promote prosecution and demand science from their colleagues who investigate allegations.

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

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

Twitter:
https://twitter.com/APADiv56

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

APA Trauma Psychology Division International Student Travel Assistance Stipend to 2014 APA Convention

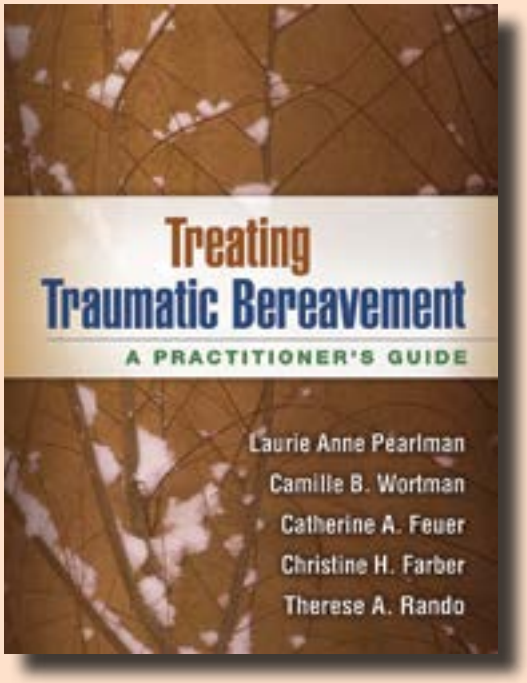
Elizabeth Carll, PhD, International Committee Chair

APA Division 56: Trauma Psychology is providing a travel stipend to assist international students enrolled in a graduate program in psychology who will be presenting a trauma related poster or presentation at the 2014 APA Convention in Washington, DC. The stipend consists of $500 plus the convention registration fee. In addition, the recipient of this travel stipend will receive a one-year membership in Division 56. Applicants must either be citizens of, live in, and study in developing countries or be citizens from developing countries who are currently attending college in the United States. The stipend is intended as partial support and applicants are encouraged to seek out additional support from other institutions and organizations. Deadline for submission is April 15, 2014.

Elizabeth Carll, PhD

In order to apply, submit curriculum vitae and convention proposal abstract to Elizabeth Carll, PhD, Chair of the International Committee of the APA Trauma Psychology Division, at ecarll@optonline.net

Newly Published Book on Treating Traumatic Bereavement



Pearlman, L.A., Wortman, C.B., Feuer, C.A., Farber, C.H., Rando, T.A. (2014). *Treating traumatic bereavement: A practitioner's guide*. New York: Guilford Press.

http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/pearlman.htm&dir=pp/taptsd

This book presents an integrated treatment approach for those struggling to adapt after the sudden, traumatic death of a loved one. The authors weave together evidence-based clinical strategies grounded in cutting-edge knowledge about both trauma and grief. The book offers a clear framework and many practical tools for building survivors' psychological and interpersonal resources, processing their trauma, and facilitating mourning. In a large-size format with lay-flat binding for easy photocopying, the book includes over 30 reproducible handouts. Purchasers can access a companion website to download and print these materials as well as supplemental handouts and a sample 25-session treatment plan.

"The authors provide important conceptual and clinical guidance, illuminating the passage to recovery and health in a way that few others have done. Impressive in its thoughtfulness as well as its comprehensiveness, this is a vital book for all clinicians—we will all find ourselves at some time or another confronting the needs and complicated care of those dealing with massive trauma and loss. This book fills a void in the literature."

—Terence M. Keane, PhD
VA National Center for Posttraumatic Stress Disorder and Boston University School of Medicine

An Infinite Mind: Bold Ideas and Hope for Those With Dissociative Identity Disorder

Lee Norton, PhD, MSW, LCSW

After decades of struggling with elusive symptoms that diagnoses never seemed to explain, Jaime P. discovered she had Dissociative Identity Disorder (DID). She also learned that her struggle for answers about DID was not unique and created an organization called An Infinite Mind (AIM) to increase client-clinician collaboration as well as provide a forum for sharing current research, new insights into effective prevention and treatment, and tools for self-care and increased self-efficacy.

Lee Norton, PhD, MSW, LCSW

"It was the only diagnosis that was helpful because it gave me a coherent and logical way of thinking not only about my symptoms, but also about how I experienced the world. The more I read, the more meaning I found. It was such a relief," she said. "I attended an ISST-D conference and realized that all people with DID should have basic knowledge about their own problem. I didn't understand why we survivors were being left out of the discussion and weren't being given the same information."

As Jaime explored the dynamics of trauma and dissociative disorders, she became determined to do something about the limited resources because her extraverted personality has been the foundation of her resiliency. A survivor of chronic childhood sexual and emotional abuse, she had organized Operation Freefall: The Two-Mile High Stand Against Sexual Assault, in which dozens of sexual abuse survivors glided to terra firma in 2000 to bring awareness to the enduring effects of rape and sexual assault.

So after her diagnosis in 2005, Jaime naturally reached out to others with the disorder through message boards and chat rooms. She led the first national peer-led DID support group that evolved into AIM, which is based upon two major premises: (1) the demystification of DID is foundational to recovery; and (2) healing depends upon clear communication and collaboration among clients, clinicians, and family/friends. In order to facilitate these goals, she launched an annual conference called *Healing Together* held in 2008 in Orlando.

"I thought, why are therapists the only ones who know about the impact of trauma on the brain and how dissociation affects all aspects of our lives? Information is the difference between having something happen to a person and having something *wrong* with a person," Jaime said. "That's the precise moment that *Healing Together* was born. I immediately saw that we all had to share what we knew, that we had to have an ongoing conversation about it, and we had to continue to discover what works and what doesn't."

Sessions are geared toward specific populations such as those with DID, supporters, clinicians, and researchers, but there are no restrictions on access to all presentations. Topics included each year span neuroscience and the biochemistry of dissociative disorders; pharmacology; clinical treatment methods, such as neurofeedback, EMDR, Internal Family Systems work, hypnotherapy, and the Instinctual Trauma Response Model; compassion fatigue; and research into the best methods for diagnosing and treating dissociative posttraumatic reactions.

Unlike most academic conferences, *Healing Together* is keenly attuned to the kind of atmosphere that will ensure the greatest learning with the least amount of activation of dissociative symptoms (whether primary or secondary). For this reason, there are areas where people can be seen quietly contemplating their own experiences, including a labyrinth for moving meditation. Space is also devoted to videotaping narratives of individual histories as well as a "trauma art" and poetry showing. Informal chat-and-chew lunch sessions encourage informal discussions where ideas can be further explored and important relationships formed.

This unique approach appears to be well received as each year has seen a 30 percent increase in attendance and more attendees have come from across the world. Attending to the sensibilities of individuals who are constantly exposed to the complexity of dissociative disorders is helpful not only to those with DID and to their families, but also to clinicians and researchers who may need reminders or lessons on how to maintain an optimum environment for approaching the complexities of dissociative experiences.

Leaders in the treatment of trauma and dissociation are increasingly supporting AIM and its programs, including McLean Hospital, an affiliate of Harvard Medical School, which provides generous

financial support each year and sends participants to the conference. Other organizations that collaborate with AIM include Pandora's Project, Center for Trauma Therapy, and the International Association for Trauma Professionals.

AIM has invited all Division 56 members to consider submitting proposals for next year's conference, which will be in February in Orlando.

Lee Norton *has worked with trauma and dissociation for over 20 years. She studied with trauma pioneer Charles Figley, PhD, and has taught traumatology at the graduate level at Florida State University and University of Tennessee. She is director of Center for Trauma Therapy (CTT), which provides a multidisciplinary approach to the treatment of trauma and dissociation. Dr. Norton has taught extensively on the topic of traumatic stress and dissociation and has applied her knowledge in capital cases, where she has been appointed as an expert witness in the field of social work and the effects of trauma on perception, judgment, and behavior.*

Trauma Amongst Adults With Autism Spectrum Disorders (ASDs)

Kristen Montague, LMFT, PsyD

Autism Spectrum Disorders (ASDs) have increased in prevalence over the past few decades with recent statistics suggesting that one in every 88 children in the United States is diagnosed with an ASD (Centers for Disease Control and Prevention, 2012). Unfortunately, the reasons for this increase are not fully understood and the search for understanding is further confounded by the complex etiology, idiosyncratic presentation, and the psychological community's changing conceptualization of ASDs.

Kristen Montague, LMFT, PsyD

As our epistemology has evolved and diagnostic criteria changed, the determination of who has an ASD has expanded over time. These historical factors influence the individuals who were seen as having an ASD, and it was not until the publication of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R; American Psychiatric Association, 1987) that ASD was understood as being a childhood disorder with accompanying pervasive developmental difficulties. Consequentially, there is a population of individuals born in the 1970s/80s who were undiagnosed or misdiagnosed and, therefore, did not receive treatment or support to help navigate their neurological differences.

It is imperative that early career professionals (ECPs) understand that there is a population of adults with ASD who have lived their lives without diagnosis or treatment and have experienced multiple traumatic events, which are relational and social in nature. Individuals with ASDs convey that the social world of neurotypicals [a term established by ASD community as a label for individuals who do not have ASD] is confusing, unpredictable, and ultimately not a place they understand or believe they belong. Social and communication impairments that are part and parcel of this disorder are further compounded by relational trauma and lack of social support. ECPs may conceptualize a person with an ASD's life experience and social/communication deficits in light of their neurodevelopmental disability rather than perceiving the interactional effect of one's neurological make-up and untreated trauma. Consequentially, assessment of trauma and its impact on one's development and communication and social impairments is imperative.

In addition, effective treatment involves understanding one's developmental trajectory as an interaction of their life experiences and neurological differences. Individuals with ASD experience a multitude of traumas across the lifespan, including sexual assault and physical and/or verbal abuse. In addition, many of my adult clients with ASD report chronic relational trauma in the form of peer bullying, social rejection, and lack of peer support. To date, there is no research available on the effects of peer bullying and lack of social support for adults with ASD. However, investigators have found that for children with ASD, frequent peer victimization was associated with numerous mental health problems, including increased anxiety and depressive symptomology, psychosomatic symptoms (Zablotsky et al., 2013), higher levels of hyperactivity, self-harming, and stereotypic behaviors (Cappadocia, Weiss, & Pepler, 2012), and lower self-esteem and anticipated future academic failure (Özdemir & Stattin, 2011). They also frequently have difficulty developing and maintaining peer friendships, which

contributes to a cycle of social isolation and loneliness. It is understood that recurring peer-victimization causes a chronic state of stress that impacts childhood development (Rigby, 1998), and, sadly, many of these observed effects remain present throughout the lifespan (Zablotsky et al., 2013). Furthermore, longitudinal research suggests a bidirectional relationship among bullying and mental health difficulties, and it is theorized that for children with ASD bullying exacerbates social and communication impairments (Cappadocia, Weiss, & Pepler, 2012).

Clinical Observations

I specialize in working with adults diagnosed with ASDs and throughout my six years of clinical experience, I have observed a pattern of symptomolgy characterized by a chronic, heightened sympathetic nervous system stress response (Williams & Guerra, 2011) that manifests in hypervigilant scanning for negative affect, sensory flashbacks of relational trauma, increased difficulty anticipating social response, emotional overwhelm/withdrawal, and avoidance of social stimuli. Clients describe a perceptual hypervigilant response to social stimuli where they "scan" interpersonal interactions for negative affect, specifically anger, in an effort to avoid negative social consequences. This "scanning" process influenced by autonomic deregulation is often followed by cognitive fatigue and somatic symptoms, such as headaches, nausea, extreme tiredness, and increased sensory sensitivity. One client referred to the effects of prolonged social engagement as a "talking hangover" while I refer to this experience as social fatigue. It is my opinion this response originated as a self-protective measure, an attempt to feel emotionally safe, to avoid negative affect expressed by others, and as a defense against social unpredictability. However, for many this self-protective strategy has become cyclic, ineffective, and further exacerbates their level of emotional distress.

In addition, there appears to be an interaction between client's neurological disposition and the traumatic effects of chronic peer victimization in conjunction with a lack of social support. For many of my clients, the combined effects of trauma and neurological differences further compound social/communication impairments and create self-identity issues where they do not understand, value, or trust their sense of intuition or own bodily responses. Individuals report symptoms of depression and anxiety in addition to unsuccessful and/or a lack of social relationships. They also describe a chronic state of hyperarousal as evidenced by observable signs of sympathetic nervous system activation: rapid breathing, sweating, cold or clammy skin, pale skin, and increased heart rate (Rothschild, 2000) in response to social stimuli/interpersonal interactions. Clients describe sensory and cognitive flashbacks of past relational trauma and report ruminating over these past experiences. The culmination of these traumatic effects impact their social motivation and capability to form secure attachments with others.

For those ECPs interested in working with individuals on the autism spectrum, it is imperative to fully assess how social interactions have affected them over time.

The core characteristics of ASDs involve deficits in emotional reciprocity and social perception. Many adults with ASD enter therapy conveying a lifetime of emotional pain and confusion in response to the social world of neurotypicals. I have repeatedly heard my clients convey some rendition of: "I do not belong here. I was not made for this world." Their life narratives are filled with experiences of social cruelty and rejection and they live their lives with little social support and few friendships. Although there is little research on individuals with ASD and the effects of bullying, it is well known that deficits in social skills and a lack of friendships are common risk factors for peer victimization (Bollmer, Milich, Harris, & Maras, 2005). The limited research that has been conducted indicates that children with ASD are at a higher risk for being victims of bullying (Zablotsky et al., 2013). It is this chronic relational trauma and social isolation combined with neurological difficulties in social and emotional perception that cause many adults with ASD to travel through life struggling with their sense of self and self-worth as well as avoiding the social situations that could potentially increase their interpersonal skills.

For many, family members are at the center of a person's social world and remain the primary and constant social interaction across their lifespan. As they age, many individuals with ASD use their cognitive abilities to further understand the cultural standards for social behavior, and develop strategies for engaging in relationships. It is in adulthood that many clients find themselves in an intimate partnership for the first time and it is within this relationship that many become increasingly motivated to understand themselves and their way of being in the world.

Clinical Example

When I met John, a man in his early 40s recently diagnosed with Asperger's Syndrome, he was anxiously pacing back and forth in the waiting room. Visibly sweating and seemingly out of breath, he turned to me and almost shouted, "I am done dealing with you fucking

shrinks! If this doesn't work I am done." I believe he called me "his shrink" for the first year in what is now our four-year therapeutic relationship.

John described a series of emotionally painful experiences with past psychologists and medical doctors, whom I imagine were well intentioned and lacking the knowledge we have today. He recalled leaving the interaction feeling misunderstood, with the implicit message that he was "inherently flawed." He had a self-protective distrust of mental and medical professionals, and our initial work involved developing a sense of trust.

Two years after our initial meeting, John and I began trauma work. John experienced chronic autonomic deregulation, which included an observable heightened sympathetic nervous system response, subsequent overwhelm, and withdrawal. He described himself as "on high alert," and regularly experienced this reaction in the presence of internal social stimuli (i.e., thoughts of past social interactions and rehearsing future social interactions) and external social stimuli (i.e., new people and past relationships associated with relational trauma). John expressed a sense of hopelessness about change and regularly considered taking his own life.

After developing distress tolerance skills and sensory-based self-soothing strategies, we used Eye Movement Desensitization Reprocessing (EMDR) to address the complex effects of chronic relational trauma. Over time, we ascribed verbal terms to John's sensory, emotional, and social experiences, and drew inferences and understandings from his past behavior and experiences. We utilized sensory techniques in the development of calming visualizations and used visual items (i.e., pictures of family members during reprocessing of trauma). After six consecutive 90-minute EMDR sessions, John reported a significant decrease in autonomic deregulation in the presence of social stimuli and an increased motivation to engage in social relationships. His depression symptoms decreased and he no longer reported being suicidal. He experienced an increased ability to understand his own thought processes and bodily responses. Overall, he reported "liking" himself and understanding his life experiences in a different way, where he was not a "jerk," "psycho," or of bad character. Rather, he and his family did their best with the information they had at the time.

John continues to struggle with social perception and interpersonal interactions; however, his ability to learn and engage in effective social strategies has increased. He is happily dating a woman who assists him in social learning in context, and, for the first time in four years, John reports experiencing enjoyment in his life and relationships while valuing the person he has become.

Concluding Thoughts

For those ECPs interested in working with individuals on the autism spectrum, it is imperative to fully assess how social interactions have affected them over time. Many individuals have experienced chronic peer victimization in concurrence with a lack of peer support, which further complicated their social development. When the effects of relational trauma are left unacknowledged and untreated, individuals experienced a pervasive, chronic stress response associated with social stimuli and in effect, human relationships. When the effects of relational trauma are brought to light and the healing begins, adults with ASD are better able to address their social and communication differences, while creating relationships and a life they enjoy living while valuing the person they have become.

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Kristen Montague, LMFT, PsyD, *specializes in working with adults with autism spectrum disorders (ASD) and with people who play a significant role in their lives. She developed and has begun piloting a social skills curriculum for adults with Asperger's syndrome that integrates current research on neuroscience, sensory integration, distress tolerances skills, and relationship efficacy skills. Additionally, she has developed and implemented trainings on the assessment and treatment of ASDs. Dr. Montague is currently completing case studies aimed at exploring the efficacy of EMDR with adults diagnosed with Asperger's syndrome who have experienced chronic relational trauma.*

Students Treating Trauma: Protecting Our Clients, Our Professions, and Ourselves

Sarena B. Loya, MS

As a student advocate for victims of sexual assault during my undergraduate years, I was exposed to individuals who had suffered a level of trauma that I had not experienced before or anticipated coping with in my personal or professional life. Neither the reading I had done nor the training I had completed fully prepared me for what it would feel like to support these victims through their pain. Sitting with clients was often painful, distressing, and disheartening. I still find it hard to believe that many of the women I worked with were my friends, acquaintances, or classmates. I was even more shocked to discover that I knew men who were perpetrators. On several occasions, a known offender chatted with me at a party, pursued a friend of mine, or turned out to be a member of my brother's fraternity.

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As a naïve college sophomore, I found myself completely unprepared for these realities, which often left me feeling scared and helpless. The way that I initially managed my stress was by increasing my dedication to my work; I read, researched, advocated, and sat with every ounce of passion and compassion I had to offer. While the work was important and rewarding, I found myself immersed in my cases even when I was not at the office. I wondered if my clients were looking for me when I was off or trying to reach me on the crisis phone while I was not on call. On many occasions, I felt guilty when I was studying, having fun with friends, or spending time with family. Constraints of confidentiality made it impossible for me to discuss my stress outside of the office and, as an undergraduate student living in a seemingly carefree environment, I imagined it would have been hard for my friends to relate.

Some of my colleagues drank to cope with the stress, some broke boundaries by meeting or talking to clients outside of the office, and others breached confidentiality to discuss client information with friends and family. These behaviors are striking ethical boundary violations that put both clients and clinicians at risk (Everall & Paulson, 2004). Constant availability to clients facilitates dependency, risks burnout for clinicians, and potentially puts lives at risk especially when novice clinicians provide unsupervised treatment. When maladaptive coping compromises our competency and ethics, we put our clients, our profession, and ourselves at risk.

Preservation of one's personal mental health poses numerous challenges when working in the field of trauma. One risk of working is increased susceptibility to "vicarious traumatization," or symptoms of posttraumatic stress resulting from indirect exposure to trauma (Elwood, Mott, Lohr, & Galovski, 2011; Pearlman & Mac Ian, 1995). Although managing patient trauma can be difficult for clinicians at all levels of expertise, students and inexperienced psychotherapists are at particular risk for experiencing distress, impairment, and vicarious traumatization. There are several reasons for this, including limited experience in the field, minimal trauma-specific training, and concerns about self-efficacy (Adams & Riggs, 2008; Pearlman & Mac Ian, 1995). Novice therapists may struggle with insecurity about how to manage trauma cases or experience symptoms of vicarious traumatization, such as having trauma-themed dreams, being easily startled, or avoiding people or places that trigger memories of a client's traumatic experience. As a result, clinicians may experience anxiety and shame regarding perceived incompetence, which may result in fear of addressing such concerns in supervision to avoid appearing inept or due to a lack of awareness that support is needed (Pearlman & Mac Ian, 1995).

Though I was formally trained to serve as a victim's advocate, I felt that my real training started when I began my direct clinical work. As comprehensive as the didactic training was, no classroom experience could have fully prepared me for the challenges that arise when working with trauma survivors. Students are particularly prone to distress and susceptible to the erosion of self-care practices and burnout (Barnett & Chesney, 2009). It is no secret that graduate students in the helping profession are generally highly motivated to serve others and are frequently willing to make self-sacrifices in order to do so. I found myself guilty of disregarding self-care practices when I began dedicating much of my free time to serving my clients. Yet, research suggests that students in training who have self-sacrificing tendencies may be particularly vulnerable to vicarious trauma and that engaging in these behaviors could result in inappropriate rescue attempts, boundary violations, or controlling behaviors that could be harmful

to clients (Adams & Riggs, 2008). For example, some advocates in my office refused to give up communication with their clients after their positions had ended. Although these students believed they were acting ethically by providing ongoing empathy and support, their actions resulted in an ethical violation that risked client safety and resulted in supervisory intervention.

So, what can we do to protect our clients and ourselves? Engaging in self-exploration and gaining insight is one of the most important aspects of being a good psychotherapist and is particularly relevant to trauma treatment. Etherington (2000) suggests that psychotherapists who are not self-aware and/or are uncomfortable with strong emotions are more likely to engage in maladaptive behaviors that could negatively impact clients. As an advocate, I realized that I had a particularly difficult time working with women who were sexually assaulted by men in my brother's fraternity. In such circumstances, my supervisor and I worked closely to determine how to best handle these cases.

Engaging in self-exploration and gaining insight is one of the most important aspects of being a good psychotherapist.

Indeed, supervision and consultation are crucial to managing the stress of trauma work. In graduate school, my supervisors have served as invaluable resources while I worked through difficult cases and my own self-doubt. Reflecting back on my years as an advocate, I now recognize that I could have benefitted from more supervision and support than I sought at the time. The challenges of trauma work became so normalized that it was hard for me to recognize the instances where additional support could have been beneficial. This personal insight highlights the importance of supervisors and supervisees both taking responsibility for understanding and addressing issues of vicarious traumatization, which can have long-term negative effects on clinicians and clients alike.

Engaging in self-care is one of the most basic concepts learned in graduate school, yet probably one of the most undervalued. In the wake of the exciting opportunities and endless responsibilities that graduate students are attempting to balance, finding time for self-care can feel nearly impossible. However, when we do not take care of ourselves, our clients suffer from our lack of presence (Baker, 2003). When I realized that my own self-care habits had greatly diminished, I committed myself to running several times a week and tutoring Hebrew. I greatly benefitted from activities that separated me from the world of psychology and were physically and spiritually enriching. I encourage all novice clinicians to discover self-care practices that are personally effective and to engage in them regularly.

Participating in ongoing education is another important practice for clinicians. Adams and Riggs (2008) found that single lectures or class discussions are insufficient for preparing students to treat trauma and indicated that students require extensive trauma-specific training in order to prevent the adverse impact of trauma work. Additionally, it seems that engaging students in more applied training would better prepare them for clinical work in trauma. For example, psychologists training novice clinicians can provide students with the opportunity to practice role-plays and shadow more experienced clinicians with ongoing supervision. The combination of applied experience and ongoing education would help ensure a thorough and well-rounded approach to training treatment providers.

I have found working in the field of trauma to be one of the most challenging and rewarding experiences in the field of clinical psychology. Given the challenges novice clinicians face, I believe that with extensive training, self-care, and conscientiousness on the part of educators, students, and supervisors, we can successfully protect our clients, our profession, and ourselves.

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Division 56 Using Social Media in Outreach Efforts

Division 56 has taken to social media to disseminate news about division activities and trauma psychology. The Social Media Committee is now active on Facebook, Twitter, LinkedIn, and YouTube in order to expand its outreach efforts and serve as an intersection for trauma-related information worldwide.

"Our goal is to further integrate social media into our publications, membership recruitment, convention programming, and activities of other committees," said Kathleen Kendall-Tackett, division president. "We have a high number of people engaging with us through these avenues, and our numbers increase every week, so clearly we are filling a need."

The division Facebook page, https://www.facebook.com/apadivision56, which has garnered over 1,000 likes since its launch in September of 2012, provides information and links on trauma from around the web such as the latest in PTSD treatment, access to a free reprint of an article on the impact of prior rape on older adults, and a video on the effect of meditation on African war refugees. The division has nearly 400 followers on its Twitter feed, https://twitter.com/APADiv56/ @APADiv56 and 190 members of its LinkedIn group. More recently, the committee created the division's YouTube Channel to expand its collection of trauma-related information into multimedia format.

Division members may promote awareness of their research, publications, awards, and other activities through all of these avenues, which link the division to numerous other organizations, including The Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Veteran's Administration, American Foreign Service Protection Association (AFSPA), and other APA divisions.

If you have any questions about the Division 56 Social Media Committee or its efforts, please contact Division President Kathy Kendall-Tackett at kkendallt@gmail.com.

Report From APA Council of Representatives

Joan M. Cook, PhD

These are exciting times to be on APA's Council of Representatives (COR). The mid-year COR meeting was held in Washington, DC on Friday, February 21st through Sunday, February 23rd. The Council, APA's Board of Directors and staff were passionately engaged in a dialogue regarding how to help APA have a more "nimble" governance structure. Below I share with you a general overview of the meeting, its spirit and a few things that may be of particular interest to trauma psychologists.

Joan M. Cook, PhD

In order to best utilize the expertise and energy of COR, its members are now focused on "mega" or overriding matters of strategic importance to the Association. Becoming a more nimble COR has involved a redistribution of some of COR's current responsibilities to address key strategic questions that APA and/or the discipline of psychology must answer.

At this meeting, COR focused on the opportunities and challenges of health care reform for psychology and psychologists. As preparation for this discussion, Council members were provided with suggested readings such as one by Dr. Katherine Nordal, the Executive Director for the APA's Practice Directorate. Her very thoughtful paper published in 2012 in *Professional Psychology: Research and Practice,* entitled "Healthcare Reform: Implications for Independent Practice" is a must read!

The reformation of healthcare financing and delivery in the United States is upon us. Council discussed ways the Affordable Care Act (ACA) might affect psychology and psychologists. Among other things, the ACA encourages the integration of behavioral healthcare into primary care settings. Through small and large discussions, Council identified numerous opportunities for the profession including clarifying psychology's identity related to primary care and identifying those advanced skills for which psychologists are uniquely qualified. The identified gaps included the need for public education about psychology's contributions to health care and our

incorporation of science and data into our health care activities. These discussions will continue. For now the conversation ended with the reminder that although the professional landscape of professional practice is shifting, psychologists have unique skill sets and, with proper planning, can flourish.

Relatedly, Council approved, as APA policy, the document *Health Service Psychology: Preparing Competent Practitioners*. This policy describes the distinctive competencies that a psychologist working in a health delivery setting should possess and discussed how best to prepare competent health service psychologists. This document is critically important as it notes how health care reform will likely make it a necessity for psychologists to shift from a primary focus on mental health to a broad focus on a range of health problems.

Council also approved the use of APA funds to create an online application system for psychology graduate programs. The platform will create a centralized system for the submission, processing and review of student applications and faculty recommendations for use by students, programs and reviewers. This is expected to be available in 2015 and is anticipated to be helpful to students and faculty by reducing the burdens associated with the current application process.

Additionally, Council adopted as policy a new *Resolution on Gun Violence Research and Prevention* (http://www.apa.org/pubs/info/reports/gun-violence-report.pdf). This policy is focused on reducing gun violence through a comprehensive, science-based public health approach. It calls for research that identifies risk and protective factors vis-à-vis firearms violence for diverse groups and for a continuum of mental health services to meet the needs both of people with severe mental illness and those in emotional crisis.

Council received the *Report of the Task Force on Trafficking of Women and Girls*. The report's aim is to raise awareness among psychologists and the public about human trafficking; make recommendations to enhance research, education and training; and urge psychologists to apply scientific research and expertise to influence public policy and enhance services to survivors of trafficking.

The next face to face meeting of COR will take place at the Annual Convention in Washington in August. If anyone has a specific question about the information presented above, please do not hesitate to contact me at Joan.Cook@yale.edu. It is my pleasure to serve as your representative to Council. Thank you for the opportunity.

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Visit http://www.apatraumadivision.org/ for information on how to join Trauma Psychology, Division 56 of the American Psychological Association and receive *Psychological Trauma* as a member benefit. Members also have electronic access to the journal through the https://my.apa.org landing page after log in.

For more information about *Psychological Trauma,* including how to submit your manuscript for consideration, see http://www.apa.org/pubs/journals/tra/

Division 56 Regains Second APA Council Seat

Joan Cook, PhD, and Beth Rom-Rymer, PhD

Division 56 has regained a second seat on the Council of Representatives (COR), the legislative body of the American Psychological Association (APA). COR speaks for APA on matters advancing psychology as a science, as a profession, and as a means of promoting health and human welfare. In addition, it generally has full power and authority over APA affairs and its funds. Thus, a seat at APA's Council of Representatives is a big responsibility and a powerful role in the Association's stewardship.

COR is typically comprised of at least one representative from every division as well as one representative of each U.S. state, provincial and territorial psychological association, and members of the Board of Directors. When Division 56 first began, we were given one seat on COR. However, over time, we were able to garner enough votes from APA members to gain a second seat. Although we lost that seat in 2012, our members came out in full voting force in 2013, and we have again gained the second seat. We want to acknowledge and celebrate the enthusiasm of our members to vote for our having two seats for the next two years! (In 2016, a new structural plan for APA governance will be enacted. It is not clear how the number of division seats will be apportioned at that time.)

Right now, a second seat on the Council of Representatives means a lot for our division. With more representation in this important legislative body, we can speak up more forcefully on the COR floor about issues that affect trauma training, research, and practice. We can also align more easily with representatives from other divisions and states, provinces, and territories to ensure that our action plans can be implemented. Furthermore, we can solidly solicit the many caucuses of the APA Council to support our political positions. With this newly earned second seat on COR, the voice of trauma psychologists will be heard even more clearly and loudly. Congratulations, colleagues, for a job well done!

Division 56 Program for the 122nd Annual APA Convention

Walker Karraa, PhD, Program Co-Chair, Division 56

Division 56 program committee members have been working hard to organize the programming for the upcoming 122 Annual Convention in Washington, DC, from August 7 to 10. With 22 symposia and 70 posters planned, Division 56 promises to bring the most compelling research and dialogue regarding the full spectrum of trauma psychology.

We are excited to announce that in the first year collaborative programming was instituted at APA, three of the 77 collaborative presentations selected by the central programming committee (CPG) are from Division 56. In one such collaboration, we are the lead division on *Addressing Health Disparities in Trauma-Informed Care: Researcher, Education, and Training*, chaired by Sandra Mattar, PsyD, Division 56 Council Representative, working with Division 45 (Society for the Psychological Study of Ethnic Minority Issues) and Division 27 (Society for Community Research and Action: Division of Community Psychology).

Our other collaborative programs include *Hospital-Based Violence Intervention Programs: A Trauma-Informed Program at a Teachable Moment*, which was submitted by Division 48 (Peace Psychology) along with Division 27 (Community Psychology); and *Advancements in Partner Violence Research: Measurement, Longitudinal Patterns and Conceptual Models*, led by Division 16 (School Psychology), also in collaboration with Division 27.

The presidential address, chaired by Division 56 President Kathleen Kendall-Tackett, PhD, will feature a presentation titled *Integrating Mental Health and Trauma Care into Health Care Globally*, and will feature Elizabeth Carll, Laura Murray, and Ellen Garrison. Other invited presenters include Gil Reyes, Richard Tedeschi, Darcia Narvaez, and Wendy Middlemiss.

We are delighted to be working with this year's hospitality suite coordinator, Nnamdi Pole, to create a dynamic suite program. If you are interested in volunteering for helping out in the hospitality suite, please contact us at c.cueavas@neu.edu; walkerkarraa@yahoo.com.

Attendee registration begins April 15, 2014. For more information about the general convention, please visit http://www.apa.org/convention/index.aspx.

Walker Karraa, PhD, *is maternal mental health advocate, researcher and author. Her upcoming book, Postpartum Depression: Trauma and Transformation, will be published Fall 2014. www.walkerkarraa.com*

Call for Division 56 Awards Nominations 2013

Division 56: Trauma Psychology is now accepting nominations for its awards on outstanding contributions to the field. It's easy to nominate! Just send your nomination in the body of an email or as an attachment (electronic submissions only) to the Awards Chair, Charles Figley, at Figley@tulane.edu.

In the nominating letter, it is of utmost importance to explain the candidate's suitability for the particular award, their accomplishments, and specifically, their contributions made to the field of trauma psychology. Please also include a copy of the nominee's curriculum vitae. Self-nominations are accepted. **Deadline: April 20, 2014.**

Previous winners are listed on the Division's website: www.apatraumadivision.org.

Award for Outstanding Contributions to Practice in Trauma Psychology

This award recognizes distinguished contributions to psychological practice. It may be given for the development of a highly effective intervention, for contributions to practice theory, or for a sustained body of work in the field of trauma psychology practice.

Award for Outstanding Contributions to the Science of Trauma Psychology

This award recognizes distinguished contributions to scientific research. It may be given in recognition of a particular discovery or for a sustained body of research and scholarship.

Award for Outstanding Service to the Field of Trauma Psychology

This award recognizes sustained contributions of leadership in the field of trauma psychology.

Award for Outstanding Dissertation in the Field of Trauma Psychology

This award recognizes the most outstanding dissertation defended in the prior academic year on a topic in the field of trauma psychology. Quantitative, qualitative, and theoretical dissertations are all welcome. Nominations must include a copy of the dissertation abstract and a manuscript or publication derived from the dissertation. Dissertations must have been defended in the previous year (January-December 2012).

Award for Lifetime Achievement in the Field of Trauma Psychology

This award recognizes a distinguished senior psychologist who has made outstanding contributions to science, practice, advocacy, and/or education/training over the course of his/her career. These contributions would have advanced the field of trauma psychology.

Award for Outstanding Media Contributions to Trauma Psychology

This award recognizes the creator(s) of media presentations for lay audiences that educate the public in a scientifically sound manner about the psychology of trauma. Any kind of work available in any form is eligible (e.g., written word, film, video, web, graphics, etc.). Fiction and non-fiction representations are equally welcome. Nominations should include the names of the creator(s) of the work being nominated, as well as either a full sample of the work being nominated, or a web address for the nominated work, or both.

Award for Outstanding Early Career Achievement in Trauma Psychology

This award recognizes psychologists in the early stages of their careers who have shown outstanding achievement or who have made outstanding contributions to the study of psychological trauma. Nominees' contributions may be in the areas of clinical practice/research and writing or basic/applied empirical research. Nominees should have earned their degrees no more than seven years prior to the year in which they are nominated. For the year 2013, eligible individuals will have received the doctoral degree in 2006 or thereafter.

Early Career Awards for Ethnic Minority Psychologists in Trauma Psychology

This award recognizes those ethnic/racial minority psychologists who have made outstanding contributions in the study and practice of trauma psychology within seven years of graduating from doctoral programs. Nominees' contributions may be in the areas of clinical/practice, research/writing, basic/applied research, or other professional contributions (e.g., governance/leadership) and are more heavily weighted toward nominees who have made contributions in traumas affecting or are associated with ethnic minority status/issues. For the year 2013, eligible individuals will have received the doctoral degree in 2006 or thereafter.

APA Adopts a More Efficient Governance System

From the APA Governance Affairs Office

Over the past several years, the APA Council has been working on developing a more nimble, efficient and responsive governing system, as part of the APA Good Governance Project (GGP). This project was an outgrowth of the strategic plan focused on optimizing organizational effectiveness. APA's existing governance system is a 1950's model built for a world where twice annual meetings was sufficient for conducting the business of the association. The new model, proposed after a thorough assessment with input from many different groups, has 3 primary goals: nimbleness, strategic alignment across the organization and increased member engagement. Under this model, members will have a more direct voice in the decision-making process and more opportunities for service.

In February 2014, Council voted to begin a 3-year trial delegation of authority to the Board of Directors for: financial and budgetary matters; oversight of the CEO; alignment of the budget with the Strategic Plan; and internally focused policy development. The Board composition changes with 6 member–at-large seats now open to election from and by the general membership, the addition of a public member and the guarantee that both a student and early career psychologist voice will be present. Two seats are reserved for members of the Council Leadership Team, to ensure a bridge between the two bodies.

This change frees Council to focus on strategic and emerging issues affecting psychology, and will be engaged in higher level strategic dialogues that inform the development of policy and strategic directions. The work of Council will be managed by a newly created Council Leadership Team (CLT). Understanding member wants and needs related to the topics at hand will be an integral element of the deliberation process. In addition to this change in function, Council plans to consider a change in its structure this August. The current proposal retains a single seat for each division and state, province and territory, and adds a handful or member-at-large student and early career representatives. The attributes of the at-large seats will be determined based on an annual needs assessment to determine what would best help create a balanced Council.

These changes, coupled with a more efficient triage system, improved integration of technology, a formal leadership pipeline and development program and other enhancements, will allow APA to be more responsive to the needs of its members, to allocate resources more efficiently and to address emerging issues in a rapidly changing environment head on. Members will be have the opportunity to vote on new bylaws language this fall that will optimize APA's governance system for the 21st century.

For additional information on the implementation of the Good Governance Project, please visit http://www.apa.org/about/governance/good-governance/index.aspx or contact Nancy Gordon Moore, PhD, MBA, Executive Director, Governance Affairs at nmoore@apa.org.

Attorney General Holder to Keynote APA-ABA National Conference on Confronting Family and Community Violence Edit

Violence in homes and communities, its impact on children and families and how to confront the issue effectively are the focus of the joint APA and American Bar Association continuing education conference. "Confronting Family and Community Violence: The Intersection of Law and Psychology" will be held May 1-3 in Washington, DC. Keynote speaker, U.S. Attorney General Eric Holder Jr. will discuss recent national efforts to address the impact of violence on children and families, including his Defending Childhood initiative. More information: http://www.apa.org/about/offices/ogc/apa-aba/conference.aspx

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

Why join Division 56?

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

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

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

Member Benefits

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

Join Division 56 Now!

Membership Category	Rate	Journal
☐ APA Associate/Member/Fellow	$45.00	included
☐ Professional Affiliate*	$45.00	included
☐ Early Career Psychologist	$35.00	included
☐ First Year APAGS	Free	$22.00
☐ Student	$10.00	$22.00

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Method of Payment

- ☐ Check Payable to Division 56
- ☐ Visa
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*__Professional Affiliate Membership__ is offered to individuals who are not members of APA. Applicants in this category must submit a description of professional training in trauma psychology or a related field, a curriculum vitae, and the name of a current member willing to provide a brief statement of endorsement. These materials should be submitted to the current Membership Chair at APADiv56Membership@gmail.com,

TRAUMA PSYCHOLOGY NEWSLETTER

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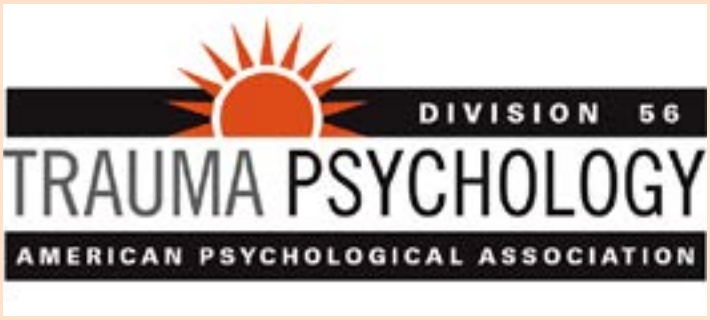
EDITORIAL STAFF



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

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

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

PUBLICATION SCHEDULE

Issue	Submission Deadline	Publication Date
Winter	February 1	March
Spring/Summer	June 1	July
Fall	October 1	November

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

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Ad Size	Rate*
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