

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

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NEWS

PRESIDENTIAL VOICE

Becoming More Disability Friendly: Trauma Psychology and People With Disabilities

By Kathleen Kendall-Tackett, PhD

At one of my first APA conventions,

I attended Ken Wallston's presidential address. Ken was the president of the Division of Health Psychology. During his address, Ken outted himself as a person with a disability and described his life with muscular dystrophy, a condition that many of his family members shared. His disability was not obvious, but it had a significant impact on his career and life.



Kathleen Kendall-Tackett, PhD

why I think it's relevant to trauma psychologists (fully acknowledging that my experiences do not represent the experiences of all people with disabilities (PWD)).

During my time in APA governance, on the Committee for Disability Issues in Psychology (CDIP), I learned that APA recognizes three major categories of diversity within the organization: racial/ethnic minorities, LGBT, and people

continued on p. 3

Over the following year, Ken became my mentor. He was a big part of the reason that I became an APA Fellow in Health Psychology. Like Ken, I too have a disability that is not obvious but affects me every day. I'd like to follow Ken's example of sharing my experience of disability, how it impacts me, and

Convention Issue

SEE PAGES 6-8



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Presidential Voice

continued from p. 1

with disabilities. As a division, we have done an outstanding job of making sure that racial/ethnic minorities and LGBT are included in our Executive Committee and leadership structure, and on the editorial board for the journal; however, the same has not been true for individuals with disabilities. As former secretary for the Division, I know this is true because I used to complete our diversity statement every year as part of our annual report. We had many members of the Executive Committee (EC) who either identified as racial/ethnic minorities or as members of the LGBT community. I was usually the only one with a disability. This suggests that our Division is not putting enough emphasis on including PWD in the governance structure. I hope that by highlighting my experiences I can provide some ideas about how we can improve.

Physical Barriers and Challenges

My disability is the autoimmune disease lupus. I had my first major outbreak of symptoms in 1990, but it took another seven years before I was diagnosed. That's fairly typical with these diseases because symptoms can be vague and patients are often not believed when they report symptoms to their health care providers. Lupus is one of the 159 types of inflammatory arthritis. These diseases are also known as collagen-vascular diseases, and for me, that description is apt. I have very fragile connective tissue, which means I'm double-jointed. It also means that I get injured quite easily—and all the time. I've broken five bones and had numerous sprains. (I was once at an APA governance meeting and tore a hole in the connective tissue in my abdomen. I ended up at my surgeon's office when I got home). I also had a spinal fracture 12 years ago that led to significant neuropathy in both legs, which means pain and impaired proprioception. The result of this is that I fall a lot because I can't quite feel the ground. I missed a stair last year in Canada, which led to two sprained ankles and two broken bones in my foot. I spoke at my last two conferences for the year in a wheelchair. I now walk with a cane and sometimes a walker.

The vascular part of collagen-vascular is also apt. One common symptom of autoimmune diseases in this class is involuntary vasospasms, which turns our hands and feet blue, which is known as Raynaud's phenomenon. Unfortunately, Raynaud's has also affected

the vasculature of my lungs, which turns my lips blue. Hang around me long enough and you will eventually see it. (Don't freak out. It's normal for me.) These vasospasms in my lungs have me in the borderline range for something called pulmonary hypertension. That is a very bad condition with a near 100 percent fatality rate. I have had two really big scares with it in 1997 and 2006. Fortunately, it doesn't seem to be progressing; however, I have an echocardiogram every year to check for it and that potential diagnosis is always hanging over my head.

Even with all of the above, I lead a very full and normal life: I work a lot of hours; speak at all-day conferences; travel internationally, often by myself; and hang out with family and friends. But the physical challenges are many and I need to make accommodations. With accommodations, my life is normal. Without accommodations, my life is hard. For example, I need to take rest breaks during my workday, so I sometimes work strange

hours. Stairs are kryptonite for me, so I need to either be in places without stairs or that have an elevator. (It's super annoying when people tell me, "it's just one flight.") I also need to be careful with how much I'm on my feet, as lots of walking or standing on hard surfaces leads to lots of pain that can last for days.

When it comes to APA, I would say that my greatest physical barrier is the convention. It is, by far, my most physically demanding conference and it is not disability friendly. Anju and her staff at the APA Disability Services Office do their best to try to accommodate us, but there is only so much they can do with the sheer size of the venue. For me, the Orlando convention was particularly hard. In fact, I ended up in pain management for 6 months when I got home.

The convention becomes less physically challenging when programs are not spread across the venues. It also helps when sessions are not so tightly timed that participants need to rush from one thing to the next. It's often impossible to make it to sessions on time when they are back to back in different venues. So spreading them out a bit time-wise and/or having them in the same venue helps a lot. Another simple accommodation is to have chairs during receptions and social hours. It's hard for some of us to stand for long periods of time, which makes it difficult for us to attend these events.

I'd like to see more people with disabilities involved in the Executive Committee and in the Division as a whole. Why? Because we have a unique and helpful perspective to share.

Social Challenges

People with disabilities also have to contend with thoughtless things people say, another term for which is microaggressions. As with anything, it depends who's saying it and how they say it. If it's someone who knows me well, I'm less likely to take offense. But often it's someone I don't know at all, who nonetheless feels free to offer unsolicited advice about my life. These statements are not the end of the world, but they do create an atmosphere that is not disability friendly and people in our Division are not exempt. Here are some examples of conversations I've had with Division members over the past couple of years.

"You don't look disabled." It's really hard to know what to do with this kind of comment. It's usually meant as some type of compliment, although it's pretty left-handed. Considering that many of us went undiagnosed for years because our symptoms were not believed, these type of statements tend to be irritating. It's like the person saying it is denying our reality. As in, "you say you are sick, but I don't really think you are." One particular person was so persistent with these types of comments that I actually pulled out my driver's license and showed her the little disability symbol on it. I should never have to do that with anyone.

"Have you tried (MSM, Tahitian Noni Juice, mindfulness/other helpful remedy....)? It cures lupus." These types of statements annoy the crap out of me. I have an entire team of health care providers, both traditional and alternative, whom I trust and who keep a very close eye on me. I see a health care provider at least once a week. Even with that, people think I am just clamoring for their input into my health care. Now if a close friend tells me about something interesting that they ran across, I'm willing to listen. But often it's someone who doesn't know me well, who knows nothing about my illness, and assumes that my team and I have missed something important. It's annoying and insulting. To those folks, I want to say, "Don't worry, I've got this."

"Are you taking time for self-care?" Please don't misunderstand me on this; I think self-care is important. And as Charles and Kathy Figley suggest, I have self-care buddies who keep me accountable. The problem is that when you have a disability, people assume it's because you are not taking care of yourself. Lack of self-care is not what caused our disability, and suggesting it is insulting. Moreover, self-care is not an option when you have a disability. There is no margin for error. A non-disabled person can ignore self-care for weeks or months before it becomes a problem. Not so for me and others with disabilities. I've got a couple of days, tops, before I must attend to it.

On Becoming Disability Friendly

Between physical and social barriers, PWD may choose to join other divisions that quickly provide the necessary accommodations. I believe our low number of members with disabilities reflects this. After last year's accident in Canada, I realized that I was going to need a physical accommodation for this year's APA convention. I've never asked for one and was frankly amazed at the pushback I got. I kept asking and did get what I needed. But here is my concern: I'm the Division president and have been on the EC since the beginning. Even in my position I had to keep asking and was fortunately empowered enough to do so. My experience makes me very concerned about what it would be like if a student or early career practitioner member needed an accommodation. If they encountered the pushback I did, they would have (correctly) surmised that our Division is not disability friendly and would go elsewhere.

I hope we can change this. I'd like to see more people with disabilities involved in the Executive Committee and in the Division as a whole. Why? Because we have a unique and helpful perspective to share. In the same way that we value the perspectives of racial/ethnic minority and LGBT psychologists, we should also value the perspectives of psychologists with disabilities. This is especially important for trauma psychologists because many of the people either in our studies or in our practices have disabilities (e.g., a high percentage of people with chronic pain syndromes have trauma histories).

If we want to include PWD, we need to become more disability friendly. We can do that by being willing to accommodate disabilities (e.g., have places to sit at social functions, don't have functions in places that are not wheelchair accessible). Don't say silly (and rude!) things like, "it's just one flight of stairs." And if someone needs an accommodation, do it and don't argue about it.

I believe that becoming more disability friendly will make us a stronger Division. By doing so, we will also be embracing APA's vision of an organization that is inclusive for all our colleagues.

Kathleen Kendall-Tackett, PhD, IBCLC, FAPA, is a health psychologist, International Board Certified Lactation Consultant, and the Owner and Editor-in-Chief of Praeclarus Press, a small press specializing in women's health. She is Editor-in-Chief of *Clinical Lactation*, Fellow of the American Psychological Association in Health and Trauma Psychology, President of the APA Division of Trauma Psychology, and Editor-in-Chief-elect of *Psychological Trauma*. Dr. Kendall-Tackett is a Clinical Associate Professor of Pediatrics at the Texas Tech University School of Medicine in Amarillo, Texas and Research Associate at the Crimes against Children Research Center at the University of New Hampshire.

Convention and New Columns



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Dear Colleagues,

We are pleased to present this pre-convention issue of *Trauma Psychology News*. Division 56 President Kathy Kendall-Tackett, PhD, explores the issue of the trauma division becoming more disability friendly and provides tips for making conference presentations more accessible (p. 8). During the 122nd annual convention in Washington, DC, the division will be presenting 22 symposia, 70 posters and three collaborative events with other divisions (p. 6).

With over 1,000 presentations, addresses, poster sessions, and award ceremonies and about 14,000 attendees, the convention can be overwhelming. Feel free to retreat to the Division 56 Hospitality Suite at the Marriott Marquis to connect with colleagues and rest tired feet. APA has developed tools to help manage participation including a new mobile app and an FAQ section on its website at <http://www.apa.org/convention/about/faqs/index.aspx>. Upon returning home, please consider submitting your experiences for the next issue of TPN, especially for those members who are unable to make the trip to Washington. The deadline for submissions is October 1st.

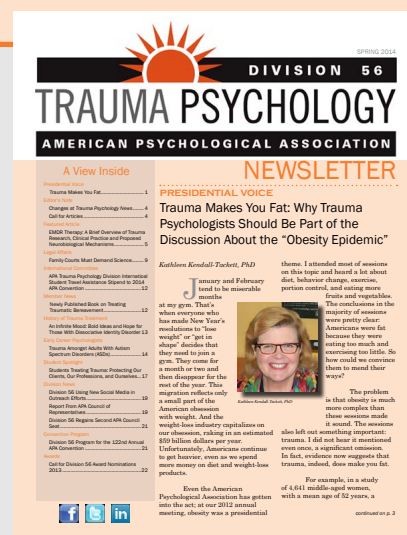
Also in this issue, we unveil new columns including news from across the division and its membership that will showcase events, awards, and other achievements (pp. 18 & 21). Please consider submitting your information to us. Under the editorship of Nicholas Wood, PhD, the Multimedia Reviews department launches with a look at the movie *The Perks of Being a Wallflower* (p. 19). Send submissions for this new area to Nick at nickwoodpsy@gmail.com. We expect to continue introducing new columns and anticipate launching the online version of the newsletter early next year with an issue focusing on international trauma psychology with topics ranging from treatment to research and training to advocacy. Those interested in participating in this special section should contact Elizabeth Carll, PhD, Chair of the International Committee, at drcarll@optonline.net.

I look forward to seeing many of you soon!

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

Call for Articles

Trauma Psychology Newsletter is now accepting submissions for the Winter 2015 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 October 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, LMFT, tpndiv56editor@gmail.com, and Associate Editor Tyson Bailey, PsyD, tdbaileypsyd@gmail.com.



Division 56 Program for the 122nd Annual APA Convention



Traffic lights around the Lincoln Memorial.

By [Walker Karraa, PhD](#), Program Co-Chair, Division 56

Division 56 program committee members have been working hard to organize the programming for the upcoming 122nd Annual Convention in Washington, DC, from August 7-10. 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.

Collaborative Programming

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, in collaboration with Division 45 (Society for the Psychological Study of Culture, Ethnicity and Race) 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) and in collaboration with Division 27.

Presidential Address

The presidential address, chaired by Division 56 President Kathleen Kendall-Tackett, PhD, FAPA, includes the 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.

Awards Reception and Social Hour

The Awards Reception and Social Hour are Friday, August 8th, 6:00 PM - 7:50 PM, at the Marriott Marquis Washington DC Hotel, Independence Salon A.

Suite Program

Student/Early Career Psychologist/Senior Professional Mixer (Thursday, 8/7, 5:00 pm - 6:50 pm)

Contact: Nnamdi Pole; npole@smith.edu

Description: This program provides students and early career professionals with the opportunity to network with and receive mentoring from senior professionals in the trauma field. It is also an opportunity for senior professionals to get to know the next generation of trauma specialists. Refreshments will be served in an informal atmosphere. No need to reserve your spot. Just show up and meet some new people who share your interests!

How to Obtain Excellent Trauma Training: Internships, Postdocs, and Beyond (Friday, 8/8, 12:00 pm - 1:50 pm)

Contact: Maria Espinola; me402@nova.edu

Description: This program will focus on the issue of how to specialize in psychological trauma at the end of graduate training. A panel of recent trainees and training directors from different trauma-focused VA settings, university clinics, community mental health centers, and hospitals will lead the discussion and share their insider knowledge. Space is limited. Reserve your slot with Maria Espinola.

How To Design a Course on Trauma Psychology (Friday, 8/8, 2:00 pm – 4:00 pm)

Contact: Nnamdi Pole; npole@smith.edu

Description: There is widespread and increasing interest in trauma psychology but relatively few courses on the subject in most colleges and universities. This discussion will be led by experienced teachers: Nnamdi Pole, Amber Douglas, and Bethany Brand. The goal is to share successful models of trauma courses with recommended readings, videos, exercises, activities, assignments, etc. Those who are currently teaching trauma courses are encouraged to bring copies of their syllabi to share. Those who are planning to teach trauma courses in the future are encouraged to bring their questions and concerns. Space is limited. Reserve your slot with Nnamdi Pole.

Setting Up a Forensic Trauma Practice (Saturday, 8/9, 2:00 pm – 4:00 pm)

Contact: Nnamdi Pole; npole@smith.edu

Description: Laura Brown, Lisa Rocchio and Steve Gold will be holding a two hour training on the practicalities of setting up a forensic trauma practice. You will not only learn some do's and don'ts, but will also come away with valuable resources. This training costs \$35 but is free to Division 56 members. We will accept the first 12 reservations but take others if space allows. Reserve your slot with Nnamdi Pole.

Research Mentoring (Saturday, 8/9, 4:00 pm – 6:00 pm)

Contact: Nnamdi Pole; npole@smith.edu

Description: Do you have a paper you want to publish or a design or statistical problem on your trauma paper



The Washington Monument, just one site to visit in Washington, DC.

or trauma-related dissertation? We have reserved two hours in the suite for mentoring. If you email the nature of your issue, we can try to pair you with a major researcher in trauma, an editor or associate editor of a trauma journal, or a methods expert. Mentoring sessions will last half an hour, and need to be booked prior to the convention. Send your request to Nnamdi Pole who will attempt to match you with a mentor. For those outside of Division 56, there is a \$35 charge for this meeting but is free for Division 56 members. Please sign up in advance.

For more information about the general convention, please visit <http://www.apa.org/convention/index.aspx>.

Walker Karraa, PhD is a Research Fellow at the Center for Leadership Studies, School of Advanced Studies, University of Phoenix, and Media Review Editor for the Journal of Leadership Studies. She is Media Director for the International Marcé Society, and Founder of Stigmama. Her upcoming book, *Postpartum Depression: Trauma and Transformation* will be published this coming Fall, 2014. www.drwalkerkarraa.com

Making Your Conference Presentation Accessible to People With Disabilities

By Kathleen Kendall-Tackett, PhD, Committee on Disability Issues in Psychology, and Scott Feldman and Monique Williams, APAGS

As you prepare for this year's conference, we'd like to encourage you to make your presentation accessible to people with disabilities. This is probably a new idea to you. It's natural to think of accessibility in terms of physical space, but not in format of presentations. But consider for a moment how frustrating it would be to attend a conference, and miss most of what is said. That's what happens to many of our colleagues.

Disabilities are not always obvious. People may have visual or hearing impairments. They may have learning disabilities or other types of print impairments that make it difficult to process written text. Fortunately, there are some simple steps that you can take to ensure that your presentation is accessible to everyone in your audience.

Use a Microphone. In oral presentations, use a microphone whenever you can. We realize that you may not always have a choice about whether a microphone is available. But to the extent that it is possible, use a microphone so everyone can hear you. Also, when there is audience participation, encourage people asking questions to speak into a microphone. If a microphone is not available for the audience, you should repeat the question into yours.

Present in Multiple Formats. When you are speaking, you should also have visuals available (e.g., overheads, slides or PowerPoint). That way your presentation is both visual and auditory, thereby increasing the likelihood that people who do not hear well, will at least be able to see it and people who don't see well, will at least be able to hear the information. This is a good teaching practice anyway, even when presenting for people who don't have disabilities. Finally, be sure to read out loud text that you have on your visuals. Do this even when you have a graph, cartoon or picture. Tell the audience what the picture says. This will also help if your session is being taped.

Use a Large Font, Bulleted Text, and Lots of White Space. Give some thought to your overheads or slides. It's best if they are written in at least a 28 point font. Overheads and slides are also clearest if they are black print on a white background. Try not to pack

too much information on each slide. These are hard for everyone to read.

For poster presentations, similar rules apply. Some presenters try to put way too much information on their posters. Your audience will be able to better process your information if you don't try to cram too much information into a small space. Use a large font, bulleted text, and lots of white space. This will be much easier for everyone to read.

Have Handouts/Papers Available on Disk. Handouts are always a good idea for helping people remember what you say. But for people with visual, learning or print impairments, typical paper handouts aren't particularly helpful. Having your handouts available on disk will allow attendees with disabilities to use software to read them. If you forget to bring disk copies of your handouts (1 or 2 copies on disk are usually enough), you can also offer to e-mail this information.

Any text on disk is better than nothing. But if you really want to be helpful, there are some additional steps that you can take. Many people with disabilities have computer programs that will read text out loud. You can format your text on disk in such a way that it takes maximum advantage of these programs. First, it's helpful if you can have your handouts or papers in Word since this is a pretty universal format. Some still use text, but many more are using Word, and if necessary a Word file could be easily converted to a text file. Formatting paragraphs with a blank line between each helps to permit reading by paragraph. The font size and style make no difference, as the person's access technology will adapt it. Any figures and tables should be labeled as such, and it also really helps to have a note indicating "end table" or "end figure" at the end to permit a reader to skip over them as desired. Ideally, figures could be described in a note by the author, but this is not standard practice.

In conclusion, there are some positive steps that you can take to make sure that your presentations are accessible. By making some of these small adaptations, you can ensure that everyone who attends your session can find out about your work. And ultimately, these changes also benefit you because they will make you a more effective presenter for everyone in your audience, not just people with disabilities.

An Update on Treatment Research for Severe Dissociative Disorders

By Bethany L. Brand, PhD, and Aliya R. Webermann

Prevalence of Dissociation and Severe Dissociative Disorders

Dissociative disorders (DD) and dissociative symptomatology, including Dissociative Identity Disorder (DID), are found throughout the world (Lewis-Fernández, Martínez-Taboas, Sar, Patel, & Boatín, 2007; Spiegel et al., 2013).¹ In a community probability study of over 25,000 respondents from 16 countries, Stein et al. (2013) discovered high levels of dissociation among 14.4% of those with Posttraumatic Stress Disorder (PTSD). Studies in the United States, Canada, Europe, Australia, and Turkey have found that DID is linked to antecedent severe, repeated childhood abuse, as well as poor attachment experiences in childhood (e.g., Dalenberg et al., 2012; Martínez-Taboas, 1991; Middleton & Butler, 1998; Ross et al., 1990b; Sar, 2011). DD patients report more chronic, severe and early onset of abuse compared to patients diagnosed with other psychiatric disorders (Boon & Draijer, 1993). Objective documentation, including police records, child protection records, and/or witness accounts have substantiated the self-reported histories of childhood maltreatment among individuals with DID (Coons, 1994; Lewis, Yeager, Swica, Pincus, & Lewis, 1997; Martínez-Taboas, 1991).

Treatment Outcomes of DD Patients

The expert consensus guidelines for treatment of complex DD support the use of a phasic trauma treatment model that specifically targets dissociative symptoms (Brand

et al., 2012; International Society for the Study of Trauma and Dissociation [ISSTD], 2011). DD patients show improvements in symptoms and functioning when provided with treatment that is consistent with these guidelines (e.g., Brand, Classen, McNary & Zaveri, 2009). In addition, several early case series demonstrated that treatment for DD is beneficial. For example, Kluff's (1994) case study review suggested that DD patients improved over time with treatment; patients in treatment for longer periods of time showed significantly higher rates of symptom reduction than those in brief treatment. Ellason and Ross's (1997) inpatient study and Coons and Bowman's (2001) case series found that DD patients who remained in treatment showed significant improvements in depression, dissociation, PTSD, and somatoform symptoms. Both groups documented that those patients who achieved integration of their self-states showed more improvement than those who did not. Ellason and Ross (1997) followed 135 DID patients treated in a trauma unit for two years after discharge. At follow-up, patients showed significant decreases in dissociation, depression, general psychiatric symptoms, medication use, and in a number of Axis I and II disorders. Patients' scores on all subscales of the Dissociative Disorders Interview Schedule also improved. The study's findings are strengthened by their use of a structured diagnostic interview to establish diagnoses and assessment of a wide range of outcomes, but weakened by a high drop-out rate and lack of control group.

Authors (Brand, Classen, McNary & Zaveri, 2009) who conducted a meta-analysis of eight DD treatment studies found moderate to strong within patient effect sizes with decreased dissociative and posttraumatic symptomatology, suicidality, and general distress.

The Treatment of Patients with Dissociative Disorders (TOP DD; Brand et al., 2013) study was a longitudinal, prospective, and naturalistic study of 280



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¹DID and most dissociative disorder not otherwise specified (DDNOS) patients experience many similar symptoms and require similar treatment so are included in this review and referred to as "DD" (ISSTD, 2011).

DD patients and 292 therapists. Data was collected four times across 30 months; clinicians could provide patient data regardless of whether patients dropped out of the study, accounting for the discrepancy in patient and clinician sample sizes. This study has the largest and most geographically diverse sample of DD patients in a treatment study to date. Patient and clinician reports indicated that over 30 months of treatment, DD patients showed significant decreases in dissociative, posttraumatic, and depressive symptomatology, as well as decreases in overall distress, drug use, and physical pain. Clinicians reported that patients' Global Assessment of Functioning scores increased significantly over the course of the study, which suggested improvements in daily and interpersonal functioning. In addition, clinician reports demonstrated that patients improved in adaptive behaviors related to social, volunteer, and academic pursuits. Secondary analyses (Cronin, Brand, & Mattanah, 2014) demonstrated the importance of a strong therapeutic alliance in positive therapeutic outcomes among DID patients, as those who had stronger relationships evidenced significantly greater decreases in dissociative, PTSD, and general distress symptoms.

A crucial element to a discussion on efficacy of treatment of DID is the importance of trauma-informed and, specifically, *dissociation-informed* therapy. Jepsen, Langeland, and Heir (2013a) followed 48 survivors of childhood sexual abuse treated for three months in an inpatient trauma unit, assessing them prior to admission, at admission, at discharge, and at a one-year follow up. They found a significant interaction between pre-admission pathological dissociation and pre-admission interpersonal functioning in predicting poor psychiatric outcomes at the one-year follow-up; pathological dissociation was the sole significant predictor of poor outcome at program discharge. In addition, DD patients' psychiatric symptoms were consistently more severe and chronic in nature than non-DD patients. Given the significance of dissociation on therapeutic outcomes, the authors noted the importance of specifically targeting dissociative symptoms in treatment. Additional analyses (Jepsen, Langeland, Sexton, & Heir, 2013b) found that although the DD and non-DD groups both demonstrated improvement throughout treatment and the one-year follow-up, trauma survivors without a DD diagnosis had less severe symptoms and better functioning throughout the study while DD patients remained significantly

more symptomatic, were more dysfunctional initially, and took longer to show symptom improvement. Although DD patients benefited from complex trauma treatment, Jepsen et al. (2013b) concluded that amnesia and identity fragmentation did not improve without specifically targeting these severe symptoms.

Brand et al. (2013) and Jepsen et al. (2013a) advanced the study of treatment process and outcomes in DD patients by using large and diverse samples, standardized assessments, and more rigorous longitudinal designs. Both studies have weaknesses

inherent in naturalistic studies, including lack of a control group, and possible confounding variables including selection bias (e.g., selecting patients well-suited for treatment). Brand et al. (2013) had an attrition rate of approximately 50% for both patients and clinicians over the 30-month study.

However, Jepsen et al. (2013a) had an impressive 3% patient attrition rate during their 12-month follow up.

Brand, Loewenstein and Spiegel (2014) provide further evidence of the importance of methodological rigor when drawing conclusions about DD treatment studies. These authors reviewed claims about the alleged "harmfulness" of DD treatment and the evidence used to support these claims (Lilienfeld, 2007; Lynn, Lilienfeld, Merckelbach, Giesbrech, & van der Kloet, 2012). Contrary to the claims that DD treatment is harmful, Brand et al. (2014) did not find a single peer-reviewed empirical study showing that DD treatment results in worse outcomes for DD patients provided with treatment that is consistent with expert consensus guidelines (ISSTD, 2011). The authors determined that these claims of harm rested almost entirely on opinion pieces, autobiographical accounts written by patients, and non-peer reviewed publications, rather than reviews of the empirical literature, leading them to conclude that claims about the "harmfulness" of DD treatment lack empirical support. A valid criticism of DD treatment outcome research described by Brand et al. (2014) is that preliminary studies on DD treatment outcomes had significant methodological flaws. However, as reviewed above, recent DD treatment studies with stronger methodology continue to demonstrate that DD treatment is associated with a wide range of benefits, rather than harm, to patients.

The evidence of dissociation improving in treatment is sufficiently strong enough that those who have opined that treatment is harmful to patients

A crucial element to a discussion on efficacy of treatment of DID is the importance of trauma-informed and, specifically, *dissociation-informed* therapy.

recently made a major concession:

The evidence makes it clear that appropriate psychotherapy reduces rather than increases dissociation. Lynn et al. (2014) conceded that increases in dissociative symptoms do not follow psychotherapy in general, but stated that such increases occur only after “suggestive” therapeutic procedures. Lynn et al. offer no evidence that suggestive therapy is in fact occurring in any of these studies. (Dalenberg et al., 2014, p. 913)

Future Directions

Research on DD treatment is steadily growing and becoming more rigorous despite the difficulty of doing research with severely ill patients who require long-term treatment and cannot ethically be deprived of an intervention in order to form a control condition. The results consistently document that DD treatment is associated with improvements in a wide array of severe symptoms as well as improved well-being and functioning, although causality cannot be conclusively inferred without randomized controlled trials. Despite recent studies, much more DD outcome research is needed due to the paucity of research with this patient group when compared to other disorders. Future DD treatment research should utilize systematic interventions and control groups even though designing interventions for acutely ill patients is challenging.

The TOP DD researchers have developed the first systematic, controlled intervention for severe DD called the TOP DD Network study. Clinicians will be invited to participate with one patient with DID or DDNOS. The participants will view weekly online 5-15 minute psychoeducation videos on improving management of safety issues, dissociation, and affect. These videos were created by the TOP DD research team, who are experts in DD treatment. Patients will complete written and behavioral exercises that relate to each week's video topic. TOP DD Network participants will be statistically matched with participants from the first TOP DD study who will serve as a control group. The intervention will last one year with one year of follow-up. The goal of TOP DD Network study is to examine whether a web-based intervention in conjunction with individual DD psychotherapy yields better outcomes than individual therapy alone. To learn more about the study or to sign up to participate, visit the website: <http://topddstudy.com/>.

Conclusions

The efficacy of a dissociation-informed treatment model was initially supported through preliminary DID outcome research and continues to be supported through recent rigorous research. Patients with complex DD often report histories of severe and prolonged trauma and demonstrate a range of chronic and debilitating psychiatric symptoms that result in high costs to the

individual patients as well as the health care system. Given the prevalence of DD, the severity and chronicity of symptoms, and the high associated costs, DD treatment research is urgently needed.

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Kinaesthetic Imagining

By Ilene A. Serlin, PhD, BC-DMT

*Note: A more extensive version of this article appears in *Grief and the Expressive Arts: Practices for Creating Meaning* (Thompson & Neimeyer, 2014).*

Description

Kinaesthetic Imagining is an existential/depth form of dance movement therapy in which bodily-based images create a nonverbal narrative or text that has metaphoric, symbolic, and transformative levels of meaning (Serlin, 1996, 2010). It is compounded from the Greek word “kinesthesia,” which means “sensation of movement” (Greek: kinae—movement + easthesia—sensation). “Imagining” is an active process by which images are generated and formed. Therefore, kinaesthetic imagining is the process by which the perceptions arising from moving muscles generate and make explicit imaginative structures of consciousness. As embodied narrative or putting poesis (a poetic writing style) into action, kinaesthetic imagining is a dynamic process by which people often compose themselves and form their lives. Since grief often stays stuck in the body, moving through the images and feeling the feelings in the body is crucial for healing.

Kinaesthetic imagining has a simple three-part structure that includes (a) check-in and warm-up; (b) amplification; (c) making meaning (action hermeneutics).

Check-in and warm-up. Use of breath, sound, stretching, and circle dance movements will warm up the body, bring body awareness and consciousness to self and others, create the container, and mobilize healing energies.

Amplification. Repetition and deepening the emerging themes explores images and emotions that arise from individual, dyadic, and group movements. Participants have an opportunity to develop their own personal healing images, stories, and mythologies.

Making meaning (action hermeneutics). This is a time to wind down, internalize the imagery, reflect on its meaning, let go, and make a transition into real life.

Case Example

Marta is a 35-year old master’s student in a class on group process through movement. The class takes place in Israel during the 2006 Lebanon War. Group members are experiencing great losses and fears as sons and husbands are called to the front. During one morning check-in, Marta reports that she has had a significant and powerful dream the night before, and offers to share it with the group. I ask the group if they would like to hear and work with the dream, using movement and imagery to amplify its images.



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Check-in and warm-up. When they agree, I ask them to spread out on the mats on the floor and get into a relaxation pose on their backs or sides. I lower the lights and spread out some props on the floor, such as dream-like billowy silk scarves and a pink chiffon large stretchy fabric. I play relaxation music, something like Japanese flutes, and they sink into quiet. As they settle into the floor, I ask them to begin releasing tension, letting the floor hold them up, feeling their weight. The sensation of sinking down, trusting the floor, following the out breath by releasing muscle tension, and sinking deeper and deeper brings a state of receptive relaxation.

During this part of the warm-up, the emphasis is on learning to literally sink into the body and consciousness; thus, awakening bodily-felt sensations, which turns attention from the world outside to an inner focus and listening.

A warm-up is not always slow or meditative. Sometimes it can be active by physically isolating and warming up individual body parts, introducing rhythm and use of weight, and adding breath and space. This morning, though, was slow and dreamy.

Amplification. A critical and creative part of the warm-up is to create an environment that maximizes the journey inward. Hence, I dim the lights and simulate a familiar resting position setting in preparation for the story to unfold.

As the group settles in, Marta begins to read her dream:

The State of Israel—war in the north—I had a dream; I dreamt I lose all that is nearest to me, Arabs seize my home and take it under their control, into my sister's kindergarten bursts a strange man who proceeds to pack all the children's belongings into boxes; in one box he places all the childrens' handiwork of butterflies.

Marta then begins to recite the following poem written to describe this dream image. I notice that she is deeply moved and ask her to repeat the poem. As she does so, her voice deepens in tone and gains power. I ask her to repeat it, twice. Then she begins to rise, drapes herself in fabric and walks slowly around the room, chanting the poem. The poem grows in volume and becomes a mantra, connecting her words to her body and her breath. She circles, slowly and ghost-like, chanting:

One small room,
Lots of boxes
One box,
Lots of butterflies
A struggle
The man closes the box
A woman tries to open it
The butterflies in the box struggle to fly and be freed of
the box....
One small room.... lots of boxes...

As she circles, she creates a wind-like motion that begins to pull others into it. Slowly, others begin to rise off the floor and follow her. Soon there is a whole room full of draped figures moving dreamily around the floor. I slide the large pink sheet toward the circling figures, some pick it up and soon it becomes an undulating cover over and around them. It feels like we are undulating underwater in a primal sea.

In amplification, we begin creating the environment and increasing kinesthetic awareness. We then are ready to “seed” the images. There are many creative ways to amplify dream images, but in Kinaesthetic Imagining images are brought into the body, energized with breath and intensity, and amplified with music, props, or colors.

Meaning: Action Hermeneutics. As the group movement intensifies its imagery and emotional expressiveness, it reaches a crescendo. It feels, at that point, as if there is no single leader or follower, but everyone is caught by the same dream. The room feels

alive, no words are spoken except the poem. And then the poem stops. And the movement slows. And people begin to sink down to the floor once more.

I ask them to slow the movement down even more, beginning to feel in their muscle memories the echoes of the rhythms and color traces of this movement. We transition again to an inner quiet space where each one has some time to feel and reflect on the experience. What does it mean to you in your life? Does it remind you of anyone or of another time?

We then move back toward the circle and take time to share.

Action
Hermeneutics is the process by which the movement itself energizes and sharpens the dream image. Marta writes:

By means of the movement, by means of my participation in the movement therapy course, I search for the center part of my body and equilibrium: within my emotions, movement and thoughts... what is the center of me, the place from which my movements evolve, where the things I say come from. I felt words and movements were connected as if they were one; sometimes there was no need for words to understand about others or what I do.... We were able to turn our attention to another, to “feel” her, to touch her to touch us emotionally, spiritually and even physically...The amazing bond was between the personal dream and the group dream, in which each one could be in a place of her choice... It was wonderful how group members supported each other; joining together without words and I, in the background, used the words as mantra, repeating the words that strengthened the support of the group's physical movements.

I felt I was floating with the mantra that I had created for the group and myself; finally, I too, once a captive within, was freed.... I felt that the dream told the story of the little spirits of the entire group, and the butterflies in the box desiring to fly to freedom were a metaphor for each one of the group member's hurt spirits. This same hurt spirit desires to be free and to feel better, happier in life after the burden is released from its heart. I felt that through the dream and the movement, joint and individual, we had advanced one additional small step towards our joint task—to reach happiness.

I understood that this connection probably came from my strong unconscious thought of my connection with the Holocaust and the fear that enveloped me

during the period of the war that we experienced recently. But why a butterfly?

In the Lochamei HaGettaot Memorial Museum, a special building in memory of the million and a half children lost in the Holocaust, was built. Engraved on the metal flooring are the words: "There are no butterflies in the Ghetto"... in the museum you lift up your eyes to see a huge stained glass window illuminated by incoming rays of the sun and it depicts a colored butterfly surrounded by flowers. This expresses the memory of the million and a half little spirits lost in the Holocaust; this picture is deeply engraved within me from my visits to the museum and I continually connect the butterfly with a hurt spirit wanting to be freed. Through the experience of our group process I also was released from the visions of the little children and their spirits in the Holocaust. When I accompany a group of school pupils to Poland this will surely assist me in dealing with the difficult journey. I understood that in the group we had succeeded in sensing the great curative strength that exists in the connection of body and soul.

In the image, the butterfly was trapped behind bars, but the sun illuminates it with hope. This is the hope that I found during the war through experiencing the realization of a dream by means of Movement Therapy.

Variations and Adaptations

Kinaesthetic Imagining is improvisational and, therefore, adaptable for many settings and needs. This particular dream arose from the morning check-in. This group was capable of creative collaborations already, while many groups need more preparatory sessions.

Some groups will also need more structure. For example, a group of boisterous children would need a faster pace, shorter phrases/instructions, and a tighter structure and container. The work is an art form in which the therapist acts as a choreographer, constantly weaving in material from the group to form a live, organic, meaningful tapestry. That art form partly depends on the personality of the therapist, the experience level of the group, how long the group has worked together, and other clinically relevant material. The therapist ultimately uses aesthetic and clinical judgment to support the creative and emotional expressions of the group.

Concluding Thoughts

Kinaesthetic Imagining is a powerful process of embodiment that can help people experiencing grief and trauma feel, express, communicate, and transform strong feelings. It creates a physical container that allows strong emotions to emerge, such as those that come from facing death, the ultimate existential threat. Understanding group processes from an existential

perspective is natural in Israel, where a large percentage of the population feels existentially threatened.

The use of art, symbols and rituals, and the creative process allows people to express very powerful and frightening emotions. The capacity to symbolize helps externalize and contain strong and often nonverbal emotions (Serlin & Cannon, 2004). Through the process of Kinaesthetic Imagining, a student from Israel during the 2006 Lebanon War was able to enact a dream image of grief and loss, use group support to develop its themes and feelings, and discover its meaning for her life.

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Stepping Up to the Plate: Opportunities and Challenges for Women in Leadership

By Susan H McDaniel, PhD, ABPP, and Nadine Kaslow, PhD, ABPP

Note: This article was first published in the California Psychological Association magazine in the summer of 2014.

As we look ahead into the next century, leaders will be those who empower others.

—Bill Gates

The two of us have traveled similar paths, having met in Houston when Susan was a postdoc in family therapy and Nadine was a practicum student in child psychology. Since then, we have both taken on leadership roles in academic health centers (Susan as a Division Chief in Psychiatry and an Associate Chair of Family Medicine, Nadine as Vice Chair of Psychiatry and Behavioral Sciences and Chief Psychologist at Grady Hospital). We both did national leadership training: Nadine following Susan in the HHS Primary Care Policy Fellowship, and Susan following Nadine in the Executive Leadership program for women in Academic Medicine (ELAM). We have both been active for years in APA governance: Nadine is now the President of APA, Susan is on the Board of Directors and running for President. Susan has built a career developing primary care psychology; and Nadine has focused on suicide and family violence research, psychology education and training, and family psychology. Both are experienced journal editors. Both have much experience with the internal and external barriers to women in leadership roles of all kinds.

Answering the phone:

“This is Dr. McDaniel.”

“Can I leave a message for Dr. McDaniel?”

“No, this is SHE. How can I help you?”

How many of us have had this experience? When we started working in our respective academic health centers in the 80s, there were few women, and we were almost always assumed to be secretaries. How do we move from there to here—an era when many women want to “lean in,” step up to the plate, and provide leadership to their organizations?



Susan H. McDaniel, PhD, ABPP



Nadine Kaslow, PhD, ABPP

Women often have good interpersonal skills and high emotional intelligence. That's how we were raised. These are VERY helpful in leadership roles. However, there are plenty of other skills we must learn to be good leaders. Many women can come to the work world expecting that, like in their childhood, they will be rewarded for being good girls and not causing trouble. Unfortunately, at least in academic health centers, this behavior often results in taking the woman's skills for granted rather than developing her abilities and maximizing her contributions.

We will address some of these challenges in this article, starting with assessing the alignment of the system with the woman's goals, then reviewing issues of power and dependency in leadership, and concluding with conflict management skills. This treatment is only an appetizer in a very rich meal; we hope you will consider some of the references for more in-depth treatment of these subjects.

Alignment

Opportunities for leadership can arise in planned or unexpected ways. One key consideration is the alignment of the mission, values, and culture of the institution with your own. We find it *very* useful, as a first task, to write a personal mission statement. Most of us have

participated in writing mission statements for our department or organization. Spend 20-30 minutes writing one for yourself. Whenever we are making difficult decisions about priorities, we return to our

personal mission statements and ask what is most important in achieving our personal goals. Not who will we please, or will we be good for the job, but is it in line with what we care about most? Is it how we want to spend our energy, our precious time? Personal mission statements are also useful to read just before going into a difficult meeting. They ground us in our commitments, and help to quell the reactivity so common to our species. They also evolve over time, and are worthy of rewriting annually.

After writing a personal mission statement, the next step is to assess the psychological health of the organization for which you may become a leader (McDaniel, Bogdewic, Holloway, & Hepworth, 2008). Does it have a clear mission and identified goals? How do these match with your own? More generally, do its leaders communicate clear expectations for its workers? Does it have a mentoring system and foster career success? Are its resources aligned with its stated priorities? Does it conduct formative reviews? Does it acknowledge employee value and contributions? Do leaders have strategies to help individuals having difficulty? Does it afford latitude for employees with changing life events? Does it have fair and systematic mechanisms for dealing with disruptive behavior?

Power and Dependency

Leadership, by definition, means confronting issues of power and dependency. The American Heritage Dictionary lists four definitions of power, the first being “the ability or capacity to act or perform effectively.” Not until the 4th definition do we get to “the ability or official capacity to exercise control or authority.” It is this definition that implies domination, and can be problematic for clinicians in relation to patients and other team members. The antidote to power as domination is shared power, or caring. Caring consists of being present, listening, demonstrating a willingness to help, and an ability to understand—people talking *with* each other rather than *to* each other, interactions based on a foundation of respect and empowerment (McDaniel & Hepworth, 2003). Sometimes that means finding out the behaviors that the other person experiences as respectful or empowering, or reporting on behaviors we appreciate.

The sociology of superordinates tells us that there are predictable feelings and behaviors experienced by those higher in the hierarchy, as well as by those perceived as lower (Goode, 1980). In particular, those higher tend to experience their position in terms of feeling burdened and responsible rather than powerful,

blessed, or lucky. Those lower can feel that their talents or accomplishments go unrecognized. They can be vulnerable to feeling invisible, unappreciated, disrespected, and, eventually, resentful. Understanding these dynamics can help to provide appropriate support to leaders or followers, and move the culture towards one of collaborative respect.

Conflict Management

Effectively managed conflict promotes cooperation and builds healthier and more positive relationships (Coleman, Deutsch, & Marcus, 2014). Conflict management refers to using strategies that moves the conflict toward resolution without escalation or destruction of relationships. A strong overall

approach to conflict management includes an appreciation that conflicts are complex and thus require differential tactics of management based upon the people involved, the situation, and the style of the parties. It entails

thoughtful consideration of the myriad sources of conflict (e.g., misunderstandings and miscommunications, fear, failure to establish boundaries, negligence, need to be right, mishandling differences in the past, hidden agendas, and the intention to harm or retaliate). Conflict management efforts must involve a detailed analysis (i.e., scientific approach) of the facts of the situation and attention to the feelings and perceptions of the parties.

The first step to managing a conflict is identifying the critical issues related to the situation, as well as associated organizational, personal, and cultural factors. Encourage each party to ask him/herself a series of questions, such as “how does my behavior contribute to the dynamics? What elements of the situation am I able and willing to change? What matters most to me/ to the other party in the situation?” If you are a party to the conflict, ask yourself these questions.

Finally, take a clear and direct, but respectful and caring approach to addressing a conflict. It is critical that you define the situation in terms of a problem that calls for a solution (Fisher, Ury, & Patton, 2011). All parties must acknowledge their feelings and acknowledge the feelings of other(s). Then ask for specific behavior change and hear the behavior change requests of the other party/parties. This involves being clear about the outcome you want, accepting what you can get, giving up on having to be right, and demonstrating your willingness to hear the other party’s perspective and to work collaboratively. Following this, share what you are willing to do to improve the situation and strive to do your best to make these changes.

In conclusion, women bring many talents to leadership. Like other important decisions in life, it takes courage to “step up to the plate” but it is also a rewarding opportunity to serve. We all need ongoing coaching and feedback regarding challenges related to defining our personal mission; ensuring its alignment with the institution, agency or organization; and managing issues of power, dependency, and conflict. We need your talents in this time of transition!

Susan H. McDaniel, PhD, ABPP, is the Dr. Laurie Sands Distinguished Professor of Families & Health, Director of the Institute for the Family in the Department of Psychiatry and Associate Professor in the Department of Family Medicine at the University of Rochester Medical Center. She has held many prominent leadership positions within APA and is currently a candidate for APA President.

Nadine J. Kaslow, PhD, ABPP, is the 2014 President of the American Psychological Association as well as Professor and Vice Chair of Emory's Department of Psychiatry and Behavioral Sciences, and Chief

Psychologist at Grady Health System. She has expertise in suicide and family violence, depression and PTSD, women's mental health, and psychology education and training. A federally funded researcher with close to 300 publications, she is a frequent media guest and the Psychologist for the Atlanta Ballet.

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DivisionNews

DivisionNews

Division 56 Webinars

Division 56 initiated a series of webinars in late June, kicking off with *Why Child Abuse Makes People Sick: The Lifetime Health Effects of Childhood Abuse* by Kathleen Kendall-Tackett. The event was a rousing success with over 100 registrations. The next webinar in mid-July had almost as many people attending *Understanding and Treatment of Sexually Trafficked Children, Teens and Young Women* by George Rhoades. If you missed the presentations, they will soon be archived online.

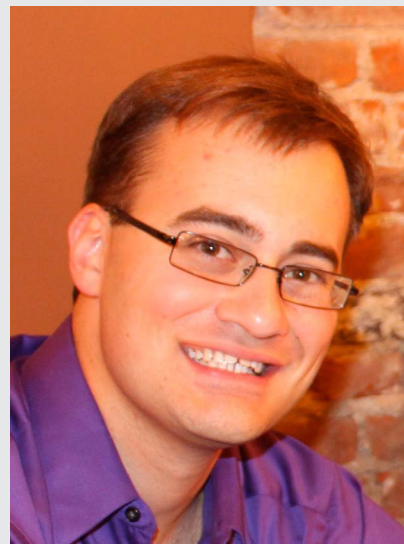
To submit your items for **Division News** — information about divisions events, awards, and other achievements — send to tpndiv56editor@gmail.com.

We Are Infinite: Review of *The Perks of Being a Wallflower*

Welcome to the new Multimedia Review section of TPN. We hope that this will be an enjoyable and informative new addition to the newsletter, and we are very much looking forward to your input and submissions.

I find it really helpful to use films in many of the courses I teach, particularly in my trauma courses. When students view their favorite films through the lens developed in their trauma coursework, they begin to see differently, to observe human behavior differently, and to better understand the many aspects of the aftermath of an overwhelming experience. I am certain that many TPN readers have also found that films and other multimedia presentations have impacted their practice, the development of their research questions, and their students' growth into empathic and trauma-informed professionals.

We plan to present a review of some multimedia presentation in each issue of the newsletter. These may be cinematic films, as in Emily Schademan's discussion of the film *The Perks of Being a Wallflower* in this issue, or they may be reviews or commentaries on television shows, podcasts, youtube channels, trade-specific videos, educational resources, or any other multimedia presentation that exists. Please consider writing for this section. If you are interested, you may send submissions, questions, ideas to Nick Wood, PsyD at nickwoodpsyd@gmail.com. If you would like to write a review, but you have not yet found the ideal subject for you, please contact me and I can help. Let's have fun here addressing difficult and complex topics, and I do look forward to reading what everyone has to offer!



Nick Wood, PsyD

—Nick Wood, PsyD

By Emily Schademan, MS

Directed by Stephen Chbosky, *The Perks of Being a Wallflower* is about Charlie, a self-declared “weird kid who spent time in the hospital.” The film is as much about trauma in its content as it is in its process. Charlie and friends experience a great deal of trauma, but the shots, lighting, *mise-en-scène*, and settings also tell a great deal of the trauma story. Chbosky balances the pain and anguish with the beauty and wonder of recovery. He does this both explicitly and implicitly, which makes room for subtlety and for a powerful telling of the story. It is the way in which this story is told that may benefit trauma professionals. *The*



Emily Schademan, MS

Perks of Being a Wallflower reminds professionals of both the glaring reality of trauma as well as its more subtle complexities.

One of the most notable aesthetics of the film is the lighting and the camera work. The film is a very dark film, but there is also contrast between light and darkness. Additionally, there are no widescreen shots, but rather only narrow glimpses into Charlie's world. For example, there is a scene of a football game, which only showed about 30 yards of the football field whereas other films may have panned the entire field and all of the fans in the stadium. This contrast allows the viewer to focus very narrowly on what's happening.

Much like a person who has experienced trauma, the viewer can only focus on certain objects and actions. Herman (1997) writes that “psychological constriction becomes an essential form of adaptation” and that the “narrowing applies to every aspect of life—to relationships, activities, thoughts, memories, emotions, and even sensations” (p. 87). Chbosky visually captures this narrowing throughout the film with both camera work and setting choice. The narrow camera shots and darkness may have also reflected the smallness of Charlie’s world. People who experience trauma often become isolated and removed from their communities. This is only further emphasized by the setting choices. The settings are limited to a few family homes, the high school, roads, and a park. Charlie admits that his world is small in the beginning of the film when he shares that he had spent most of the summer with his family and had interacted with almost no one else. The darkness in the film may also hint at some of the depression Charlie may be experiencing.

The film does a careful job of illustrating traumatic flashbacks. Throughout the film, Charlie experiences flashbacks to the time spent with his aunt and her untimely death. Charlie’s flashbacks feature small snippets of the story and tend to be very repetitive. For instance, when he flashes back to the time in his front yard with all of the luminaries, he really only recalls his aunt saying, let’s keep this our “little secret” and then imagines her car crash. Charlie’s flashbacks do not feature the entire story, but rather small, disjointed pieces of the story. The flashbacks feature mostly images and words rather than real action or movement. For a great portion of the film, it is even unclear that these flashbacks are about a traumatic experience. Instead they seem to be about the last few moments Charlie shares with someone he loved dearly. Herman (1997) writes about how the “intense focus on fragmentary sensation, on image without context” is a key feature of flashbacks that elicit a sense of heightened reality (p. 38). After each flashback, Charlie seems to be far away and his mood seems to change, which indicates the negative power of the flashbacks.

With utmost subtlety, the viewers learn that the beloved aunt Helen actually sexually abused Charlie at a young age. Near the end of the film, Charlie, for lack of a better phrase, “breaks down.” As he realizes his social network is moving away, he loses the ability to cope with the pain of the sexual abuse and subsequent shame he has experienced. When he calls his sister, he tells her that it is his fault that his aunt Helen died and that he

actually wanted her dead. It is clear from this scene that Charlie had been carrying around a great deal of shame and pain. The film carefully captures the secrets and the dynamic in an abusive relationship. Charlie idolizes aunt Helen, but then later acknowledges that he wanted her dead. According to Van der Kolk (2007), “people may turn towards the sources of their fear for comfort: both adults and children tend to develop strong emotional ties with people who intermittently harass, beat, and threaten them” (p. 200). Charlie worships his aunt Helen and even tells Sam, the girl he is in love with, that she is just like her.

In perhaps one of the more poignant moments of the film, Charlie asks his psychologist in the hospital, “How do I stop seeing it?” The “it” that Charlie refers to is not just his own pain, but the pain of everyone else around him—his sister who is being abused by

her boyfriend, Sam who was sexually abused at the age of 11, Patrick who is nearly beaten to death because he is gay. Herman sums up Charlie’s experience quite well: “small, seemingly insignificant reminders can also evoke these memories, which often return with all the vividness and emotional force of the original event” (Herman,

1997, p. 37). The pain that he watches others experience triggers his own deep pain and causes him to experience flashbacks.

Some of the greatest beauty in the film happens as Charlie begins to heal. Herman (1997) states that one of the steps to recovery is connecting with others. At the start of the film, Charlie is very isolated. Slowly, he becomes friends with Sam and Patrick and then expands his circle from there. As he becomes more connected, the flashbacks are still present, but seem to be less frequent and shorter in duration. Charlie even tells his brother that he is not picturing things anymore and that if he does he can shut it off. According to Herman, “the survivor is lucky enough to have supportive family, lovers, or friends, their care and protection can have a strong, healing influence” (1997, p. 63). Charlie’s new friends celebrate and support him while also acknowledging his pain, which gives Charlie room to heal. He moves from being an isolated and passive adolescent to a connected and active one.

At the end of the film, Charlie says “we are infinite.” He may be referring to his newfound adolescent freedom, but in many ways this statement feels like he is saying that he is no longer defined by trauma, but rather now he is a multi-faceted human being who has

unlimited potential. He knew that he was no longer a “sad story” as he recovered to a full person with talents, skills, beliefs and dreams. Herman states about the process of healing trauma: “resolution is never complete, it often sufficient for the survivor to turn her attention from the tasks of recovery to the tasks of ordinary life” (1997, p. 212). At the end of the film, Charlie tells his “friend” that he may not be able to write because he may be too busy trying to participate in life. Charlie is shifting his attention to the tasks of ordinary life.

This film is important for teachers, students and practitioners of trauma because it illustrates the importance of noticing details and complexity and it provides hope for recovery. The effects of trauma cannot be contained in a small, narrow description. Instead, the effects are varied, they ebb and flow, and sometimes they are entirely unique to an individual. *The Perks of Being a Wallflower* reminds the community of trauma professionals to notice subtlety, be patient and to remember that “we are infinite.”

Emily Schademan earned a Master of Science degree in Clinical and Counseling Psychology from Chestnut Hill College in 2013. She previously earned a Bachelor of Arts in English with a Minor in Business Administration from Villanova University in 2008. Her graduate clinical experience focused on co-occurring disorders and trauma work. In the future, she hopes to pursue doctoral work and to explore her research interests, which include the college student population and the psychological implications of living in poverty.

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MemberNews

MemberNews

Position Available

The Headington Institute, based in Pasadena, CA, seeks a highly experienced doctoral level licensed clinical psychologist with strong collaborative skills to assist humanitarian relief and development workers and emergency first-responders as “Director of Strategic Partnerships and Consulting Psychologist.” Details can be found at <http://www.headington-institute.org/>

To submit your items for **Member News** — information about divisions events, awards, and other achievements — send to tpndiv56editor@gmail.com.

Krithika Malhotra Receives 2014 Division 56 Student Travel Stipend

Members of the International Committee are participating in two internationally focused Division 56 sessions at the 2014 Annual Convention in Washington, DC. George Rhoades is a participant in the workshop, “Living Under Fire—The Global Health Effects of Living in the World’s Most Dangerous Regions,” chaired by committee member Gilbert Reyes. International Committee Chair Elizabeth Carll is a participant in the symposium “Integrating Mental Health and Trauma Care Into Health Care Globally,” which is chaired by Division President Kathleen Kendall-Tackett and also includes fellow committee members Laura Murray, Jorge Rodriguez, and Ellen Garrison. These are just examples; other committee members are participating in other Division sessions.

The committee continues to collect information on international trauma psychology programs both within the United States and globally. If you are aware of such programs, which are university based or established as ongoing institutes, please send information to Dr. Elizabeth Carll, Chair, Division 56 International Committee, at ecarll@optonline.net.

—Elizabeth Carll, PhD, International Committee Chair



Elizabeth Carll, PhD

To encourage participation of international students at the APA convention, Division 56 approved a \$500 International Student Travel Stipend and complimentary convention registration to support travel. A free one-year membership in Division 56 is also included. The recipient of the 2014 Division 56 Student travel stipend is Krithika Malhotra from Mumbai, India. She is a 4th year graduate student in Counseling Psychology at the University of Miami and is presenting as part of a symposium titled, “Women’s and Girls’ Increasing Presence in Multiple Arenas of the Justice System—Psychologists’ Roles,” at the APA convention in Washington, DC. The symposium focuses on evidenced-based practices in domestic violence and child maltreatment cases.



Krithika Malhotra

Malhotra is the first author of three journal articles in preparation and is the co-author of a 2014 chapter on domestic violence. She is also currently the coordinator for two projects at the Educational Well-Being Research Center, School of Education and Human Development at the University of Miami, where she is a doctoral student. One project focuses on domestic violence, child protection and custody while another on the involvement of fathers in the lives of their children. She is also active in leadership positions in various graduate student organizations.

A thank you to Carl Auerbach, Georgi Antar, Vincenzo Teran, and Gilberte (“Gigi”) Bastien, who served as the selection subcommittee of the International Committee to determine the recipient.

CRATER Therapy for Veterans With Mild to Moderate Cognitive Impairment and Comorbid PTSD

By Harriet K. Zeiner, PhD

In patients with comorbid Acquired Brain Injury (ABI) and Post Traumatic Stress Disorder (PTSD), standard practice in the VA is to treat PTSD first then refer for treatment of the ABI, including the use of cognitive remediation (reduction of cognitive deficits by training to improve or compensate with strategies, attention, memory, language or executive function). This article presents an alternative treatment model used at the Palo Alto VA Health Care System: treatment of the ABI with CRATER Therapy followed by PTSD treatment using Prolonged Exposure (PE), Cognitive Processing Therapy (CPT) or Acceptance and Commitment Therapy (ACT).

CRATER Therapy is one-on-one psychotherapy with embedded cognitive remediation for mild to moderate cognitive deficits, focusing on strategies used in social settings. It was developed in response to repeated findings that cognitive remediation for those with ABI results in increased functional gains during and at the end of training sessions, a decrease in gains at three months, and no effect one year post-training. The results were primarily due to the following psychological factors not being addressed in “pure” cognitive retraining:

- Regardless of warnings that cognitive strategies must be used lifelong, patients want their *memory, speed of processing, attentional focus, and ability to multi-task* to return to previous levels and manner of

processing. Patients consider these cognitive characteristics to be a part of the self, and they want to return to former levels of wholeness and competence. They do not want to appear different from peers.



Harriet K. Zeiner, PhD

- Acknowledging damage to the self is difficult, cannot be a one-time event, and must not be socially stigmatizing.
- Cognitive deficits result in the individual's thinking abilities being overwhelmed in social situations. The overwhelmed person gives a consistent catastrophic dysphoric affect that is frequently seen by others as a psychiatric difficulty rather than as a cognitive difficulty.
- Most cognitive deficits with accompanying catastrophic reactions appear in social situations; most cognitive remediation is not taught in the social context whether the training is one-on-one or in groups. Patients are expected to generalize strategies for use in the social context on their own.

CRATER therapy has six important components, encapsulated by acronym:

- **Catastrophic reaction:** tying the socially acceptable cognitive strategy performance to the symptom of cognitive overload in the environment that evokes it.
- **Regularization** of the sleep/wake cycle to reduce fatigue and provide physiological anchors for cognitive strategy performance.
- **Alliance** between therapist, patient and significant other to
- **Triangulate** and
- **Externalize** the blame for symptoms to something outside of the patient.
- **Resilience** by coping rather than by competing as competition is no longer an option for most patients.

- Group cognitive retraining is almost always totally ineffective; patients are unable to keep up, get the point, remember the material, or stay focused. In other words, patients with cognitive impairment fail in groups because of their cognitive deficits even when mild.

The evidence from holistic, milieu ABI programs is clear: success in the community, work or school after cognitive remediation occurs if treatment includes cognitive remediation *integrated* with psychotherapy (Cicerone, 2008; Klonoff, 2001, 2007; Malec, 2002). The same

techniques work for varied ABI conditions: traumatic brain injury, stroke, brain tumor, encephalitis, and Mild

Cognitive Impairment. The ability of the patient to use remediation unassisted, ally with therapists, and reduce the effects of slowed information processing appears predictive of outcome success in the community one year or more post-treatment.

The Components of CRATER Therapy

CRATER therapy has six important components (see figure on previous page).

The patient learns to identify the catastrophic reaction (Goldstein, 1943) resulting from cognitive overwhelm in social situations. There are six possible reactions, but individuals display only one or two consistently:

- Flight, avoidance
- Anger (simplifies the complex demand which elicits the overwhelm; other people go away as a result)
- Laughing (rare)
- Crying (often mistaken for depression, but can be distinguished as it immediately ceases if the situation simplifies)
- Freezing, mind goes blank
- Confusion (the patient does not ask for clarification, but impulsively jumps into action or speech, usually incorrectly)

In CRATER therapy, the patient uses the inevitable catastrophic reaction as the cue to perform a strategy that slows the world down to a manageable speed and level. This helps those with cognitive deficits who see the world as coming too fast or as demanding of impossible multitasking. The response strategy must be socially acceptable so that patient does not look unusual and must be taught to patients not “discovered” by them.

Regularization of routine, including rise time, bedtime, and mealtimes (with food taken every two to three daylight hours to maintain blood sugar) creates a behavioral schedule and physiological anchors for attachment of behavior chains, reducing the burden on memory and initiation.

The “ATE” component is the formation of an *alliance between therapist, significant other, and patient, as well as triangulating and externalizing blame to the ABI*. This tactic removes censure from the patient, allowing the family member to be educated about brain injury symptomatology. It also gives the patient a reason to contain the effects of brain injury or they will continue appearing unreliable to others. Patients learn that *reinforcement and self-esteem come from being resilient*,

which is defined as controlling the rate of information that comes at them. The world is socially too fast when it cognitively overwhelms them. It is the patient’s responsibility to slow the rate down using communally acceptable, overlearned phrases when cognitively overwhelmed.

Patients with ABI often have lowered ability to learn and remember compared to their pre-morbid characteristics. After ABI, learning and memory characteristics are often qualitatively as well as quantitatively different from that of peers. Although neuropsychological evaluation accurately describes the level of impairment of learning and memory (mild, moderate or severe), evaluations cannot describe the new characteristics (how many repetitions over days until a new material is reliably available in social situations). New learning characteristics have to become a process variable in therapy, constantly fed back to patients when they successfully learn in small steps.

Implementing CRATER Therapy

Treating ABI, not PTSD, initially. Patients with mild to moderate cognitive impairment and comorbid PTSD receive CRATER therapy first. Patients learn to modulate the rate at which information comes at them prior to initiating PE, CPT or ACT. Patients are seen in 90-minute sessions, weekly, for six months. If available, a significant other is present in most sessions; they learn what the patient learns, especially how long it takes the patient to overlearn (so that the strategy is available even in stressful social situations). The same therapist treats the members of the couple, sometimes individually, sometimes as a dyad. The relationship is not the focus of treatment as it is in couple’s therapy; the emphasis is on teaching the patient to slow the world down with overlearned strategies given to catastrophic reaction cues. Patients undergo CRATER individually if no partner is available.

Schedule regularization. After an initial explanation of CRATER therapy, regularization of rise time, bedtime and mealtimes is attempted, over a minimum time period of one month.

Use of a handheld application for cueing and scheduling support. Use of Planning and Execution Assistant and Trainer (PEATTM) software (Levinson, 1997) via smartphone is taught simultaneously during regularization training. PEATTM is a voice-cued calendar and memory prosthetic; single events during the day are stored and later cued. Software includes features that can be tied to physiological anchors. An example is a cupcake icon (“PEATTM Dessert”). After every meal, the patient presses the cupcake icon on the phone screen. This action immediately shows today’s and tomorrow’s events in the calendar, orienting the patient to what is coming up in the next 24 hours. All that needs to be learned is, “After you eat, press the cupcake.”

Stages of learning. The amount of time it takes to learn each smartphone or PEATTM software feature is taught to the patient as a stage of learning: “first learn with assist, then learn to cue, then spontaneously perform the task as overlearned.”

Addressing the catastrophic reaction. The patient learns to identify his or her consistent catastrophic reaction and what elicits it in social settings then learns to perform the strategy that compensates and/or slows information down in a socially acceptable way. Examples of some strategies are:

- *Inability to keep up with a conversation*—The patient gets angry, recognizes anger as the catastrophic reaction caused by others talking too fast, and asks others to repeat the information, which slows the speaker's rate.
- *Too many simultaneous demands on a patient who has trouble multitasking*—The patient's strategy is to say: “You've given me several things to do. Which do you want me to do first? Which is the most important?”
- *Freezing, going blank*—“I need to think about that, I'll get back to you shortly,” delay is utilized as a socially acceptable response.
- *Following conversation in a group meeting for a patient with attentional switching problems*—In a family meeting, the patient learns to take one person aside to have a one-on-one discussion as a response to confusion. In work meetings, the patient learns to track only one speaker in the group in order to follow some aspect of the conversation.

Couples skills. The partner is taught to give the patient one thing to do at a time, rather than a list of tasks. The partner (and therapist trainee) is educated to offer compliments realistically (in a 5:1 ratio of positive comments to one correction), and to recognize that the family needs for the patient's rate of progress may be different from the possible rate of progress (based on the patient's learning rate). Closed-ended statements are suggested to promote conversation. In sum, the ideal is to underwhelm not overwhelm.

Establishing resilience. Begin with regularization, the easiest achievable change. Encourage small step changes to ensure successes. The task of the therapist is to become the behavioral historian, using graphed feedback in session. Teach learning and memory characteristics as process. Promote the notion of “the sage,” the patient as a “wise person” who knows how to survive neurological impairment, struggle to reach skill competency a second time, achieve a meaningful life when all is not perfect, and cope with adversity and reduced life expectations.

Outcome

Our current research, currently being analyzed for publication, shows the following statistically significant results:

1. Veterans who regularize their schedule in 14 weeks show 20% more activity during the day as measured by actigraph. However, no aspect of their sleep quality improves.
2. Effects of cognitive training are seen at 3 months and 1-year post therapy in patients who show regularization of rise time/bedtime (there is significant increase in attendance of scheduled general medical appointments compared pre- and post-CRATER therapy).
3. Patients with ABI and comorbid PTSD, given a Clinician-Administered PTSD Scale prior to and after 14 weeks of CRATER training, show a decrement in hypervigilant symptomatology.

Teaching veterans with PTSD that anger or avoidance may be a sign of cognitive overload in social situations, asking others to repeat what they have said to slow the world down, and routinizing rise time/bedtime gives patients some control of the environment. They are awake when others are awake. They are practicing cognitive strategies in social situations and getting help from family members who recognize their difficulty as memory-, attention- and speed of processing-related.

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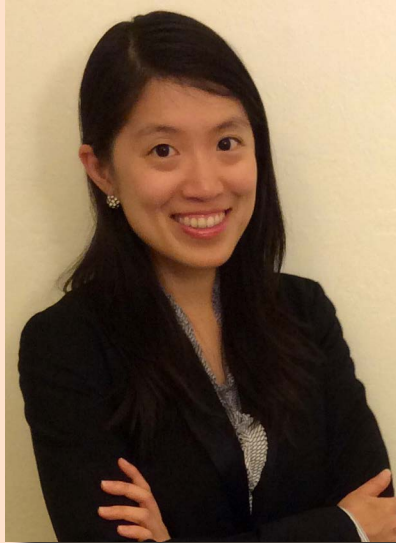
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Do Trauma and Pediatric Chronic Pain Come Hand in Hand?

A Call for a Closer Look

By Grace S. Kao, PhD

The phenomenon of pain is a mysterious and deeply affecting sensation that often signals distress. By definition, pain has been conceptualized as an unpleasant experience that involves both sensory and emotional components (IASP, 2014). In parallel, trauma symptoms also heavily involve both sensory and emotional distress. The overlap is striking and prompts questions about the co-occurrence of pain and trauma symptoms. How do traumatic experiences affect pain occurrence and vice versa? Much of the related research has been conducted with an adult population, at the exclusion of younger groups. How then should trauma and pain be understood in children and adolescents? What are the clinical implications of the potential link between trauma symptoms and pain? Unfortunately, many of these questions remain unanswered; however, for early career psychologists (ECPs) that serve the pediatric population, these questions are exciting prompts for discovery.



Grace S. Kao, PhD

Clinical Observations: Asking the Questions

As a pediatric pain psychology fellow, pain is a phenomenon I encounter on a daily basis. The multifactorial nature of pain lends to discussions of stress, mental and emotional health, and physiological arousal in pain psychology treatment. Conversations in both assessment and therapy reveal substantial emotional stressors that often vividly color patients' past experiences and influence the course of treatment. Though the majority of my patients do not meet the full Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V; American Psychiatric Association, 2013) criteria for Posttraumatic Stress Disorder (PTSD), many have histories of substantial traumatic stress, largely in the form of pediatric medical traumatic stress (PMTS) and less frequently, interpersonal trauma. The following example highlights a story that begs a further look into the inner workings of the body and its responses to traumatic stress.

To illustrate, an adolescent patient arrived for an evaluation of chronic back pain and headaches. During her initial multidisciplinary assessment, history of childhood abuse and frequent displacement was documented, and through an extensive

neuropsychological evaluation, PTSD symptoms were noted. Addressing hyper-arousal and physiological sensitivity through biofeedback training quickly became goals for treatment. Weekly outpatient therapy work that focused on relaxation and coping strategies provided substantial relief for the patient's symptoms. The co-occurring symptoms led me to wonder, "Did traumatic stress and resulting symptoms of hyper-arousal prime my young patient for chronic pain development?"

Over time, and as I completed more evaluations, collected more psychosocial histories, and learned more about my patients' pasts, I found myself documenting patients' stress in response to school and peer difficulties, past medical trauma, family problems (e.g., parent divorce, severe sibling rivalries), and loved ones who have passed away—events that occurred, in many instances, prior to development of chronic pain. My first-hand experience also paralleled further examination of the literature, where I found this pattern documented empirically in adult samples.

Trauma and Pain: Identifying the Concepts

Traumatic experiences and post-traumatic stress symptoms (PTSS) have been empirically linked to various physiological symptoms, with one of the most formidable being the development of chronic pain. The comorbidity of trauma history and pain symptoms is well reviewed in the adult population, and several theoretical models have been proposed to provide explanation (Asmundon & Katz, 2009; Asmundson, Coons, Taylor & Katz, 2002; Kulich, Mencher, Bertrand & Maciewicz, 2000; Otis, Keane & Kerns, 2003; Sharp & Harvey, 2001). Hypothalamic-pituitary-adrenal axis (HPA) reactivity (Zoli et al., 2002), shared vulnerability (Asmundson et al., 2002), and mutual maintenance of PTSD and chronic pain symptoms (Sharp & Harvey, 2001) have all been implicated in the striking correlation between trauma and pain.

Whatever the true mechanism(s) may be, childhood traumatic stress, may indeed have a profound impact on adult physiology. In fact, experiences of early life distress, such as maternal separation, infection, and injury have been linked to a broad range of health conditions such as obesity, cardiovascular diseases,

diabetes mellitus, metabolic syndrome, cancer, migraine, and osteoporosis (Bartholomeusz, Callister & Hodgson, 2013; Entringer et al., 2012; Maneypanda & Venkatasubramanian, 2005; Nijland, Ford & Nathanielsz, 2008). Medical researchers suggest that physiological responses that may be altered in response to facing traumatic stress may serve maladaptive rather than adaptive purposes when maintained beyond a stressful situation or event. When traumatic stress is conceptualized in this way, the variable then is a continuous rather than categorical one with the culmination of life stress over time increasing potential risk for deleterious health outcomes (Bartholomeusz et al., 2013).

As related to chronic pain, this conceptualization of traumatic stress's cumulative impact on the body's patterns of response may provide a partial answer to how trauma and chronic pain interact. Various studies have found childhood abuse (i.e., verbal, physical, and sexual abuse) and/or cumulative traumatic life events to significantly predict pain symptoms in adulthood (Casey et al., 2008; Goldberg & Goldstein, 2000; Kendall-Tackett, 2000). Whether it may be neurobiological changes, formation of fear structures activated by threat, or learned passive coping patterns at the root of this problem, early life stress and trauma should be closely considered in the study of chronic pain, in both adult and pediatric populations.

In Pediatric Chronic Pain: Specifying a Population

Examining the connection between pain and trauma in the pediatric population provides a greater basis for understanding the current assessment and treatment of children with chronic pain and/or PTSD or PTSS. Neurobiological changes resulting from traumatic stress have been linked to chronic pain development in adulthood, and perhaps a similar hypothesis could also be made with children and adolescents' chronic pain development. However, the comorbidity of trauma and pain symptoms, as documented in the adult population, remains quite unclear, and empirical examination of this potential link is extremely limited in the pediatric population.

To examine further, pediatric-specific questions could be asked to assess if the same correlation between traumatic stress and chronic pain development (via chronic physiological hyper-arousal) exists among

children and adolescents. Additional questions could also be considered. For example, could pain treatment approaches be specified to address the comprehensive needs of pediatric patients who have experienced traumatic stress to prevent the potential development of chronic pain in adulthood? In children reporting significant life stressors (i.e., history of familial conflict, parent divorce, bullying, and/or medical or psychological trauma), should one assume an increase in vulnerability for chronic pain development? In terms of prevention, would it be possible to identify the patients most at-risk for chronic pain development based on a history of traumatic stress? Also, how might pediatric medical traumatic stress history differ from interpersonal traumatic stress in relation to vulnerability to chronic pain development?

Clearly, there are still more questions than answers.

Future Directions: Calling for Further Examination

If a history of traumatic stress *is* linked to vulnerability for chronic pain development in the pediatric population, trauma-focused therapy may be conceptualized as a promising effort to prevent the development of pediatric chronic pain. In practice, pediatricians and primary care physicians may be in a better position to identify patients who could benefit from psychological services and provide referrals accordingly. Trauma and health psychologists could work together to consult regarding patients with pain and develop individualized treatment plans with goals for both trauma and pain symptoms. In assessment, ECPs should be aware of the correlation between trauma and pain symptoms, and psychologists working with patients who exhibit pediatric pain should screen thoroughly for histories of trauma by completing a full psychological review of systems with specific sensitivity for PTSS. Significant trauma histories should then prompt urgency for comprehensive treatment that includes trauma-focused care. ECPs are in a prime position for setting clinical precedents for best practice in the evolution of integrated care, and as such, they should be well-versed regarding the potential for comorbidity of symptoms across various areas of functioning (e.g., medical and mental health).

Overall, not only do these questions about the relationship between trauma and pediatric chronic pain, specifically, prompt further examination, but generally, they also speak to the value and excitement of the fresh

lens of an ECP and potential for empirical discovery. As ECPs newly charged with the task of improving and exploring the treatment practices in our respective fields, our attitudes and wondering perspectives attune us to areas of new discoveries. Asking questions and tracking clinical patterns come quickly and often out of necessity since the typical ECP's expertise, and finesse in ability are gained over time and experience. ECPs should strive to utilize their questions and observations for identifying future research and clinical directions. As we journey through this stimulating career phase, these questions and observations should be often noted, communicated, and discussed to promote continuous empirical understanding and more importantly, optimal enhancement in patient care.

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Treating Female Survivors of Childhood Sexual Abuse and Prostitution: Experiences and Challenges From the Field

By Katherine A. Cascio, MS

My first practicum was at a state-funded residential substance abuse treatment program, where I began treating female survivors of childhood sexual abuse (CSA) and prostitution for the first time. My clients over the year left a lasting impression on me professionally, including Amanda,¹ the third client assigned to me for individual therapy. While completing her intake, I learned Amanda's substance use began at seven when her uncle gave her alcohol to control her while he raped her. She started smoking marijuana and drinking on her own at 10 and continued both daily by the age of 14 to cope with the abuse. She eventually got pregnant and dropped out of high school, but could not support herself and her child. With few resources and using more substances to numb her pain, Amanda started trading sex for rent money and drugs.



Katherine A. Cascio, MS

After a few months, her neighbor noticed the baby's constant crying and an ever-increasing parade of men coming and going from Amanda's apartment, and Child Protective Services was contacted. Shortly thereafter, Amanda lost custody of her daughter and sunk further into addiction. The more she used substances, the more "tricks" she had to turn to support herself, and the more frequently she had to get high to cope with her circumstances. She was caught in a vicious cycle and she did not know how to escape.

As a new counselor, I was surprised by how unemotional Amanda was while disclosing her previous traumas. When she eventually opened up about her shame regarding her uncle's abuse and her involvement with prostitution, I had very little understanding of how to help anyone dealing with such severe and complex trauma. This was a sink-or-swim situation for me; I could take on the challenge of serving clients with severe trauma, or I could ignore their experiences (as so many others had), and Amanda and my future clients would continue to have their needs unmet.

While Amanda was my first client with a history of both CSA and prostitution, she was not the only one I saw that year. In my second semester, Maria was referred for treatment by Child Protective Services as a part of her service plan to reunify with her children, who had been removed following several arrests for prostitution. Maria was involved in prostitution for seven years; during that time she was in-and-out of jail, psychiatric hospitals, and shelters. Despite her history of prostitution, years of intermittent treatment, and a previous diagnosis of bipolar disorder, no one had ever asked Maria about trauma before we met.

Maria disclosed being raped by three of her older brothers throughout her childhood. She left home at the age of 16 to escape her brothers, but ended up in an abusive relationship. After she left her abusive boyfriend, she had no source of income and found prostitution to be her only option for survival. She began to use marijuana and alcohol, and eventually crack and heroin, to numb her pain. Maria was caught in a cycle similar to Amanda's; the more drugs she used, the more she had to prostitute herself to pay for them, and the more drugs she needed to cope with the trauma of prostitution.

During a particularly emotionally intense session, Maria asked me a question I was not prepared for, "Why did God put me on Earth if all I'm meant to do is suffer?" No class had trained me for this question or a client in such an existential crisis. Maria's question caused me to tear up for the first time with a client. I did not know how to respond other than to say that I wished I could take away her pain and that it hurt me to see her suffer. I am not sure if and how my statements and tears impacted Maria, but being authentic with her and acknowledging my reaction were the only counseling tools I knew how to use in that moment.

In a later session, I asked Maria something I did not think to ask Amanda, "What went through your mind before you first got into prostitution?" Maria's answer was simple, frightening, and informative, "I was used to getting raped anyway so I figured I may as well get paid for it." For Maria, and Amanda I suspect, it was a gradual, and even simple, transition from CSA to prostitution. From Maria's perspective, the two were not isolated experiences; the latter would not have happened without the former. In fact, her entry into prostitution almost seemed logical given her experiences.

¹All clients' names and identifying information have been changed to protect their confidentiality.

In the next several months, I saw three more women with histories of CSA and prostitution. Two of them echoed the simple transition into prostitution that Maria described. They reported seeing their bodies as only existing for sex or belonging to men because of CSA, and they reasoned there was little difference between CSA and prostitution.

Working with women with histories of CSA and prostitution has profoundly impacted my professional development and plans. It has opened my eyes to the outcomes of CSA in ways that are not frequently discussed in classes or diagnostic criteria. I realized that although I had been trained to work with clients with many types of trauma using existing trauma curricula (e.g., Seeking Safety), I did not know how to address many of the specific questions my clients had, such as how to disclose previous involvement in prostitution to future partners or how to explain limited work history to a potential employer. One of the biggest issues that my clients described, and I did not know how to respond to, was that they did not believe anyone, including themselves, would ever see them as anything other than “a hoe.”

After seeing Amanda for the first time, I searched PsycINFO for guidance on working with women with histories of CSA and prostitution. I learned that although women with histories of prostitution are significantly more likely to have experienced childhood trauma than the general population, most research on women in prostitution (WIP) has focused on physical and public health risks (Farley, 2003). The few studies that have investigated preexisting trauma identified that 55-90% of WIP experienced CSA (Abromovich, 2005; Bebbington et al., 2011; Choi, Klien, Shin, & Lee, 2009; Farley, 2003). Despite this prevalence, little is known about how these experiences may be connected. Most interesting and concerning is that no psychologists have asked for the perspectives of WIP on how these experiences may be related; instead, many researchers generate their own hypotheses based on the high prevalence of CSA among WIP. Overall, this lack of research makes it very difficult to provide effective and evidence-based services.

Although there is clearly a strong connection between these experiences, only a few studies have attempted to explain how CSA contributes to women's entry into prostitution. The work of Silbert and Pines (1981, 1982, 1983) attempted to understand factors that contribute to juveniles' entry into prostitution, but mostly focused on mediating variables of runaway be-

haviors and economic survival as predictors of prostitution rather than on CSA itself. However, some of Silbert and Pines' (1981) research did generate qualitative data on the connection between CSA and entry into prostitution, echoing my clients' perceptions of how their abuse had facilitated the same path. Although this information is valuable (albeit outdated) and supports my clients' conceptualizations, no research has identified specific treatment recommendations or adaptations for existing trauma interventions to address the myriad emotional, physical, and legal consequences of life in prostitution. Given this dearth of information, I was left to attempt to adapt existing trauma treatments to my clients' needs with little empirical guidance.

Based on my clinical experiences, the goal of my present research is to investigate the experiences of women who have survived CSA and prostitution and utilize their knowledge to guide the treatment of future clients like

Amanda and Maria. I hope to explain to future clients that there is a documented relationship between CSA and prostitution as a way to de-stigmatize their experiences and reduce self-blame. Moreover, I want to have evidence-based practices for treating CSA in women with histories of prostitution. Given the unique needs of this population, empirical data that focuses specifically on WIP is needed to reduce the likelihood of piecing together research on general trauma in an attempt to create an effective intervention. More generally, I want my clinical practice to inform my research, so research can inform my clinical practice. Most importantly, I want psychologists to be able to provide the best possible services to survivors of CSA and prostitution and help them heal from these experiences.

While serving women with histories of CSA and prostitution during my first practicum, I realized that I had underestimated the importance of screening for trauma and how it helps clients open-up and learn to trust you simply because you cared enough to ask and believed what they told you. I also discovered that evidence-based practice is not always possible when relevant research does not exist for the client in front of you and that clinical practice must inform research to address these gaps. I understood more clearly that research must address the unique emotional, physical, and social needs of women with histories of prostitution and CSA. Overall, I learned that when there is limited research on a particular client's issues, building a good working relationship and being authentic are most important for connecting with and serving clients best, especially those with severe trauma histories.

Most importantly, I want psychologists to be able to provide the best possible services to survivors of CSA and prostitution and help them heal from these experiences.

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Who's Who: Terri deRoos-Cassini, PhD

What is your current occupation?

I am an assistant professor with the Medical College of Wisconsin in the Department of Surgery, Division of Trauma & Critical Care. I screen, consult, and provide brief intervention with inpatient trauma survivors who have received services at our Level 1 trauma center due to traumatic injury. I also have an outpatient clinic, where I provide psychological services to survivors of trauma. I conduct research, supervise psychology graduate students in clinical care, and supervise medical students and doctoral candidates in research.

Where were you educated?

I received my Bachelor of Science degree in Zoology and Physiology from the University of Wyoming. I completed my Master of Science and Doctorate (PhD) in Clinical Psychology at Marquette University. I attended internship at the Zablocki VA Medical Center in Milwaukee and completed my postdoctoral training at the Medical College of Wisconsin.

Why did you choose this field?

When I was an undergraduate, I volunteered at a domestic violence shelter, where I saw firsthand the impact that violence has on an individual. The following year, I received an AmeriCorp position at the shelter and I had a more integral role with the survivors. It was from that time that I realized I wanted to learn more about how to help people who are experiencing symptoms after trauma.

What is most rewarding about this work for you?

To see people thrive after trauma. Because of the sudden, unexpected nature of trauma, people are often faced with situations and circumstances they never thought they would experience. Because of my position, I begin working with people soon after trauma and have the opportunity to work with them while they are experiencing physical and emotional recovery, often after severe injury. There are times that individuals talk about not seeing how they can live with different physical abilities or go back to life as it was before because of the fear they feel, ultimately not being able to see that life could be fulfilling. But then, to see

people move past that and shift focus from what they are unable to do, to what they are able to do in life and thrive, is incredibly rewarding. I feel very fortunate to have the opportunity to work with survivors during their journey.

What is most frustrating about your work?

Although I think awareness of evidenced-based treatments for posttraumatic stress disorder (PTSD) has grown substantially, I think there still is much education that is needed outside the mental health field regarding what treatments are efficacious for individuals with PTSD. There are times I have come across medical providers who are interested in using medication to treat symptoms of PTSD not because they feel that this is the best treatment option, but because they are unaware of the cognitive behavioral treatments that are efficacious. I try to use this as an opportunity to educate other providers about what the research suggests about non-pharmacologic treatment options.

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

I enjoy spending time with my husband and two kids. We are fortunate to live in a beautiful place with access to hiking, trail running, and plenty of water sports. Six years ago, I also started meditating, and I have found that this has helped me to not let the intensity of work overwhelm me—but rather enjoy the day-to-day. We also love to travel with friends and family. I have to say, working with trauma survivors also helps me to gain perspective on my own life stress—if there are situations in my life that are stressful, it is easy to draw upon what I have seen my patients go through to remind myself that what I am experiencing may be stressful, but so much different than what I have seen people overcome after experiencing a life-threatening situation.

What are your future plans?

We have a number of exciting research projects that are starting. I also hope to add another psychology position to our team. I plan to continue growing our clinical care and continuing with our research to identify risk for PTSD early after traumatic injury.



Terri deRoos-Cassini, PhD

Book Review: *Sibling Abuse Trauma*

Caffaro, J. V. (2014). *Sibling abuse trauma, assessment and intervention strategies for children, families and adults (2nd ed.)*. New York, NY: Routledge.

By Serena Wadhwa, PsyD, LCPC, CADC

Sibling Abuse Trauma (2nd edition) provides readers with a look inside a form of trauma that frequently goes unrecognized or is not often discussed. The author, Caffaro, draws experiences from his own clinical practice as well as reviews the most up to date literature and research. In this edition, Caffaro goes beyond introductory pieces on the subject, providing information on developmental issues that influence sibling relationships and dynamics, approaches to working with victims of abuse, a contextual consideration in addressing sibling-related concerns, and factors to be mindful of relating to assessment and treatment of individuals and families.

As a clinician who works with trauma and substance abuse, I found this book to be an interesting and informative resource on sibling abuse trauma. While I have not had much exposure to this occurrence in my practice, I found that the book provided terms and questions to help reframe sibling experiences and uncover and/or validate traumatic sibling experiences (abuse, violence, manipulation, etc.). Part I defines the experience and terminology associated with sibling abuse and provides a foundation for how this type of relationship develops. Caffaro explores various models that provide contextual considerations to the evolving dynamics of sibling relationships and sibling clashes. Interestingly, Chapter 1 also contextualizes reasons that sibling trauma emerges as a clinical consideration—individuals may rely more on siblings as opposed to having children that may take care of them. So individuals who have experienced sibling trauma may find themselves having to care for siblings who were abusive or be taken care of by abusive siblings, which can be traumatic and/or triggering for individuals that have not processed the initial sibling abuse.

Part I gives a great overview and concise explorations of factors that influence the sibling relationship, including how parents address children's concerns about having a sibling, how parents interact with each other and how parents interact with the child (for example, spending time with the child, etc.). The list and explanation of risk factors within sibling abuse

trauma families can be used as part of a family-of-origin assessment.

Part II explores the realm of sibling violence and sexual abuse. It was helpful to see characteristics of “normative” sexual exploration and that of sexual abuse, as some sexual curiosity is part of healthy development. In addition, Caffaro explains how sexual abuse may also involve curiosity and include coercion and manipulation. Seeing this with the differences between “normal” sibling rivalry and violence was also insightful as it framed dynamics in a certain way that may uncover the experience of abuse for the individual in therapy. For example, if a sibling has unmet needs in the family, they may turn to other siblings for emotional/psychological fulfillment that can make them vulnerable to abuse.


Part III explores the clinical practice of sibling abuse trauma. The questions within this section were helpful for exploring the dynamics and perceptions of an individual's experience and if abuse was present. For example, after reading the book, I used its assessment questions to help a client uncover a history of sibling abuse. This section also affirmed the need for individualized treatment and that healing does take time, patience, and effort. Consideration does need to be given to adult survivors and children/adolescent survivors. Recognizing that the safety of the abused is of utmost importance was also emphasized. Cultural considerations are also discussed, as race/ethnicity factors impact sibling relationships and conceptual views of rivalry, aggression, violence. While I wanted to read more about cultural factors, I recognized this was not the focus of this book.

Overall, I found this to be a great introductory and exploratory book on the concept of *Sibling Abuse Trauma* and the complexities relating to this phenomenon. Some important factors relating to development, risk and protective factors, questions to ask that can help understand the dynamics within the sibling subsystem and family systems, were explored. This book also provides much needed information and direction to working with clients that may struggle with these issues.

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Serena Wadhwa, PsyD, LCPC, CADC



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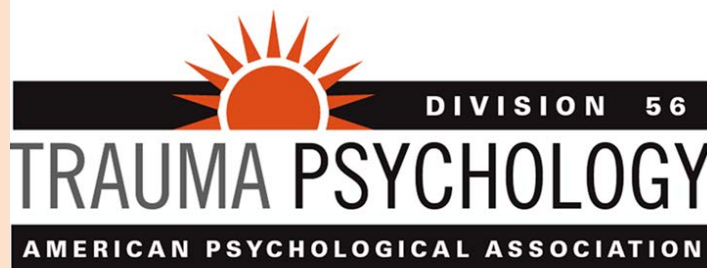
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