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DIVISION 56

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

A View Inside

NEWS

PRESIDENTIAL VOICE

Honored to Serve

By Beth Rom-Rymer, Ph.D.

I am quite honored to serve as your 2015 Division 56 President. I continue to be excited about the impressive growth of our treasury and our membership numbers even as we move beyond "newcomer" status as a division. We are now in our ninth year! Congratulations to Steven N. Gold, the very successful outgoing editor-in-chief and founder of our journal, *Psychological Trauma,* which he has led to great heights. Let's give a very warm welcome to our new editor-in-chief, Kathleen A. Kendall-Tackett, who has already created a splash with a "new look" for the journal and has had a terrific start with her first issue. We are also welcoming Steven N. Gold and Charles Figley as our two new representatives to the APA Council.

Beth Rom-Rymer, Ph.D.

Many social, academic, political issues come to the fore when we are talking about trauma. As one of my first orders of business, I am delegating task forces and ad hoc committees to create position papers for us, a project I will be talking more about in future issues of TPN.

With our 2015 convention chair, Nnamdi Pole, and our suite chair, Jessica Punzo, I have been working to create a notable convention for us in Toronto! I hope that all of you have already looked at airline reservations for your trip: convention will be from Wednesday, August 5th to Sunday, August 9th. Our theme this year is "Social Justice." Special keynote addresses will be given by Stevan Hobfoll and Bryan

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Who's Who

Turn to p. 52 to learn more about Beth Rom-Rymer

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Presidential Voice

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Stevenson, and we have some extraordinary panels covering such topics as: "The Impact of Institutional Betrayal Resulting from Law Enforcement Perpetrated Violence" chaired by Sandra Mattar; "Frodo and Sam enter Mordor: The Feminist Therapy Alliance in Complex Trauma" chaired by Beverly Green; "PTSD among Military Families" chaired by Terry Keane; "The Heavy Burden of Child Maltreatment" chaired by Constance Dalenberg; "Historical Trauma: The View through Different Cultural Lenses" chaired by Nnamdi Pole and featuring Thema Bryant-Davis, Donna Nagata, Jacob Tebes, Joseph Gone, and Rachel Yehuda; "The Trauma of Incarceration," chaired by Nnamdi Pole and featuring Bryan Stevenson as a special guest panelist; "So You want to Pass a Law: How Psychologists can Inform Public Policy at Local, State, and Federal Levels" chaired by Dan Grech and featuring Diane Elmore, Heather O'Kelly, and Beth Rom-Rymer as panelists, as well as Russ Newman as discussant; "Hope and Growth in Trauma Recovery" with Rich Tedeschi as discussant. There are many other fascinating panels with a broad spectrum of erudite presenters in our program, and many of these will also appear as Conversation Hours in our suite programming. The convention committee will continue to inform and pique your interest as we approach the convention.

An ambitious agenda for Division 56 for 2015! Please email me (docbnrr@gmail.com) with all of your thoughts and suggestions for areas in which you would like to contribute or areas in which you would like to see others contribute.

Editor's Note

Renu Aldrich's Term Managing *Trauma Psychology News* Ends

Renu Aldrich, M.A., LMFT
Editor-in-Chief

Tyson Bailey, Psy.D.
Associate Editor

Dear Colleagues,

It has been my privilege to work with so many of you while part of the *Trauma Psychology News* team these past four years. While I would love to remain, it is time for a change; and change is good.

TPN has grown tremendously since its founding in 2006, and it has become an integral part of the division. I hope that it will continue to improve and serve the membership needs under new leadership. I am extremely thankful to Tyson Bailey, who has been a wonderful associate editor. He also has been working hard to take the newsletter online as he updates the division web site, an accomplishment that will provide numerous advantages.

This is not goodbye – I will remain an invested member of Division 56 as I complete my PhD at Virginia Tech and continue my trauma work with adult survivors and South Asians living in America.

I look forward to seeing many of you in future at APA and other events.

With all my best wishes,
Renu Aldrich, M.A., LMFT
Editor-in-Chief

Introduction to the Special Section: International Trauma Psychology

By Elizabeth Carll, Ph.D.
International Editor
Trauma Psychology News

Elizabeth Carll, Ph.D.

This special section of *Trauma Psychology News* is intended to provide a sampling of the many different aspects relating to trauma work globally, including research, training intervention, social justice issues, and advocacy. The section includes nine articles describing activities spanning Africa, Asia, South America, Central America, Middle East, North America, and Europe, and at the United Nations. The articles are authored by a diverse group of psychologists, including senior and mid-career professionals, and two of the articles reflect the work of early-career psychologists. The majority of authors reside, or have resided, outside of the United States.

Several of the articles focus on low-resource, developing countries in often high-conflict areas where violence has ravaged the countries for many years and where mental health services are virtually non-existent. Thus, there is a need to train cultural leaders, health workers, and even peers in basic support skills to help ameliorate suffering. The articles in this section are provided to highlight the many different aspects and perspectives relating to trauma worldwide, and are not intended as an endorsement of any particular activity.

If you reside outside of the United States and are interested in submitting a future article, please feel free to contact me at ecarll@optonline.net, as articles from international psychologists are welcome and provide an interesting contrast to North American psychology.

Special Section: International Trauma Psychology

Guest Editor: Elizabeth Carll, Ph.D.

Going Global: Developing and Testing Evidence-Based Practices in Low-Resource Settings

Laura Murray, Ph.D.

Paul Bolton, MBBS

Judy Bass, Ph.D.

By Laura Murray, Ph.D., Paul Bolton, MBBS, and Judy Bass, Ph.D.

Global mental health is a rapidly growing area of research and policy interest within the larger global health field (Patel & Prince, 2010). Two series in *The Lancet* (2007, 2011) focused on global mental health and declared the urgent need to improve mental health services in underserved areas worldwide (Eaton et al., 2011; Prince et al., 2007). Millions of people worldwide are affected by mental disorders, which account for approximately 13% of the global burden of disease, defined as premature death combined with years lived with disability (WHO, 2008). Over 70% of this burden lies in low and middle-income countries (LMICs) (Lopez et al., 2006). Violence, abuse, and other traumas increase the risk of multiple mental health problems including symptoms of posttraumatic stress (PTS), depression, and anxiety.

The gap between those who experience mental health problems and those who receive any type of treatment is substantial. In these low resource settings, up to 90% of people needing care do not receive health services—commonly known as the 'treatment gap' (The WHO World Mental Health Survey Consortium, 2004; Saxena, Thornicroft, Knapp, & Whiteford, 2007). This article briefly describes some of the research of the Applied Mental Health Research Group (AMHR) at Johns Hopkins University. AMHR focuses on developing and testing evidence-based mental health assessments and treatments in LMICs in hopes of improving effectiveness, and ultimately reducing the treatment gap (AMHR, 2013).

The Design, Implementation, Monitoring and Evaluation (DIME) Process

AMHR was co-founded by the authors, who follow a step-wise process for understanding and evaluating mental health problems and treatments in low-resource countries. The Design, Implementation, Monitoring and Evaluation (DIME) process consists of seven main steps (see Table 1). The first step is accessing qualitative assessment records, the communities' voices on what are the most prevalent and important mental health issues for their area, and what types of interventions might be acceptable. For example, in Zambia the qualitative study identified sexual abuse, domestic violence, physical abuse, and substance use—all closely linked to HIV (Murray et al., 2006). Later steps in the DIME

Table 1
AMHR DIME Approach

1. Qualitative assessment to identify and describe priority mental health and psychosocial problems and interventions: (Module 1)
2. Develop and validate draft instruments to assess priority mental health and psychosocial problems: (Module 2)
3. Study baseline +/- prevalence surveys: (Module 3)
4. Overall program planning: (Module 4)
5. Develop interventions for priority problems: (Module 5)
6. Implementation and monitoring: (Module 4) and (Module 5)
7. Intervention assessment as controlled trials: (Module 6)

A manual describing each step is available on the web (AMHR, 2013).

Table 2
AMHR Completed Randomized Controlled Trials

Site	Population	Mental Health problem focus	Treatment(s) Studied	Status
N. Uganda	Adolescents	Trauma, depression	IPT, Creative Play (psychosocial program)	Published, 2007 (Bolton et al., JAMA)
S. Uganda	Adults	Depression	IPT	Published, 2004 (Bolton et al., JAMA)
Democratic Republic of Congo	Adults	Trauma (rape)	CPT (group), VSLA (economic intervention)	Published, 2013 (Bass et al., NEJM)
N. Iraq	Adults	Torture/trauma, and depression	BA, CPT, CETA, HA	In submission
S. Iraq	Adults	Torture/trauma, depression	CPT, CETA	In submission
Thailand/ Myanmar	Adults	Trauma, depression	CETA	Published, 2014 (Bolton et al., PLoS)
Colombia	Adults	Torture/trauma	CETA	Manuscript publication
Zambia	Children/ Adolescents	Trauma	TF-CBT	Accepted for publication

Note. PT = Interpersonal Psychotherapy. BA = Behavioral Activation. CPT = Cognitive Processing Therapy. CETA = Common Elements Treatment Approach (transdiagnostic). HA = Heartland Alliance Non-Specific Psychosocial Counseling Intervention. TF-CBT = Trauma-Focused Cognitive Behavioral Therapy

process involve adaptation and validation of instruments to assess traumatic stress symptoms (e.g., Murray et al., 2011a) and events in youth, followed by controlled trials on the feasibility, adaptations, and effectiveness of an evidence-based treatment for youth affected by trauma (Trauma Focused-Cognitive Behavioral Therapy or TF-CBT; www.musc.edu/tfcbt) (Murray et al., 2013 a, b). AMHR has done similar work in a wide range of countries including Democratic Republic of Congo, Uganda, Rwanda, Zambia, Colombia, Iraq, Georgia, Cambodia, Indonesia, Thailand, and Myanmar following some or all of the DIME steps (AMHR, 2013).

Randomized Controlled Trials in LMIC (DIME Step #7)

Rigorous evaluation is critical to understanding the feasibility and effectiveness of mental health treatments. Determining what works across cultures and situations requires trials in widely varying populations and cultures. Such trials by AMHR have found strong effects for several treatments (Table 2). These trials also examine implementation factors such as feasibility, acceptability and sustainability (Murray et al., 2014).

Training and Supervision Utilizing a Task-sharing Approach

One significant challenge in many lower-resource settings is the lack of mental health professionals (Saxena et al., 2007). All AMHR trials, and most others done in LMICs, use a 'task-sharing' approach in which individuals with minimal or no mental health background are trained to assess needs and provide mental health services that in high-income countries are usually delivered by specialists (WHO, 2008). In the majority of AMHR trials, trainers have taught individuals with approximately a high school education and no formal mental health training to provide the intervention (Table 2).

In these trials, we have found that training non-professionals in specific treatments requires an apprenticeship model (Figures 1 & 2) (e.g., Murray et al., 2011 for details). This process links trainers with evidence-based practice expertise usually from outside the project area, local supervisors who have been chosen for a more advanced role, and local providers who will offer the mental health intervention to clients. As the name indicates, the apprenticeship model is one that occurs over time

with an initial in-person training comprising only the first piece. In LMIC, the initial training lasts 10 days. Providers then participate in practice groups with five or six individuals to actively role-play different components with a supervisor coaching, and the trainer getting weekly reports via Skype. As a provider receives a case, supervision groups are run weekly, with detailed reports on every case. During this time, the local supervisor is in weekly contact with the expert, who also reviews each case. In this way, training actively continues in a cascading process throughout the program.

Comorbidity and Scalability: Use of Transdiagnostic Interventions

Given the diversity of mental disorders that can arise from trauma (depression, anxiety, substance abuse, panic, psychosis, borderline personality, etc.), and the large burden of mental disorders in low-resource settings where mental health professionals are scarce, there is a need to find treatments that address comorbidity (Murray et al., 2013b). Some mental health professionals in the United States are evaluating transdiagnostic models that teach a set of common practice elements that can be delivered in varying combinations to address a range of problems (Weisz et al., 2012; Farchione et al., 2012). Decision rules, based on research from the United States, guide selection and sequencing of elements, but allow for flexibility in individual symptom presentation (Chorpita & Daleiden, 2009; Weisz et al., 2012; Farchione et al., 2012). Based on this work, we wanted to evaluate whether lay counselors could learn this type of model that has additional flexibility compared to other evidence-based treatment manuals. In a recent study using a transdiagnostic model (CETA; Murray et al., 2013b), effect sizes in Thailand were also over 1.0 for PTSD, depression and anxiety symptoms (Bolton et al., 2014). Similarly, strong effect sizes were found for CETA in S. Iraq with adults (in submission). This type of approach could improve feasibility and scalability, particularly in areas where there are diverse presentations, limited mental health personnel, and where training in multiple EBTs is not an option.

Summary

Global mental health has gained recognition and made significant scientific contributions over the past decade. It is an exciting and emerging field with many future directions including additional intervention trials and implementation studies. Challenges remain around validated instrumentation, and in understanding what interventions work for whom and under what circumstances. Evidence of the effectiveness of some evidence-based interventions calls for implementing scientific research on how to scale up and sustain such treatments to reduce the treatment gap.

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A clinical psychologist by training, ***Dr. Laura Murray*** *is highly trained in numerous evidence-based treatments, with a particular specialty in cross-cultural adaptation processes, training and supervision. She uses the DIME approach, and conducts trials with both children and adults. Much of Dr. Murray's research focuses on implementation research.*

Dr. Paul Bolton's *main areas of expertise are research methods, program design, monitoring and evaluation. He uses the DIME approach to conduct needs assessments and to plan and evaluate programs with service providers including major NGOs. This work has encompassed programs dealing with physical health (including infectious diseases) and more recently psychosocial problems.*

Dr. Judy Bass's *work focuses on designing and evaluating methods for assessing mental health and mental illness in non-Western cultures with the intention for using these assessments to investigate effectiveness of innovative prevention and intervention strategies. She has a particular interest in socioeconomic programs and perinatal depression.*

APA Convention 2015 | Toronto | August 6-9, 2015

Despair, Disruption, Devotion: Families in Lebanon Cope with Loved Ones' Disappearance

By Kevin M. DeJesus, Ph.D.

> *"He was on his way to the bank…" – Brother of a disappeared sibling from Lebanon recounts the day his brother was kidnapped in Beirut (personal interview, 2006).*

Trauma travels into the spaces of our everyday lives. Indeed, our geography of the everyday, however mundane it may seem, is often conceived of as a mere backdrop to our lives, typically rendered insignificant in our thinking until a situation forces it into our consciousness. As the quote above reveals, our very geographies of the everyday, particularly in sites of violence and politically-motivated human rights violations, are also harrowing immersions into labyrinths of fear and potential peril to the self. For the people of Lebanon, both Lebanese and Palestinian alike, a treacherous geography of checkpoints, partition (East and West Beirut), and dominating militia-rule held sway in the face of a disintegrating state during the near two-decade long civil war. This transformation rendered everyday life a risky navigation between bombs and the barrel of a gun with one's life and fate stolen too often by the impulses and agendas of those who manned the checkpoints, and their leaders. During the Lebanese civil war, an estimated 90-100,000 persons died, roughly 17,000 disappeared, 100,000 were significantly wounded, and approximately two-thirds of the country's population of roughly 4 million people experienced forced displacement from their homes (Haugbolle, 2011).

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This long civil war, which began in 1975, came to an official end in 1990 (DeJesus, 2011) The intensity of the war yielded great humanitarian and international-scale crises, such as the massacres of both Lebanese and Palestinians civilians at Sabra and Shatilla refugee camp in 1982, the hijacking of TWA flight 847 in 1985, and the massive bombing of the US marine barracks in October of 1983. The explosion at the U.S. marine barracks was possibly the largest non-nuclear, man-made explosion ever accounted (Goodman, 2013). While those days of carnage have fortunately ceased, for the scores of families of the disappeared in Lebanon it is a conflict that haunts their minds and hearts as they endure the forcible absence of a loved one whose official status remains "whereabouts unknown."

The psychological sequelae of families of the disappeared has been long articulated, depicted lucidly in the landmark study of Chilean families by Inger Agger and Soren Buus Jensen (1996) as well more recently in the compelling work of Simon Robins (2013) with families in Nepal and Timor-Leste. It is the "ambiguous" nature of the loss yet to be resolved that pains families intensely, Robins explains (2013).

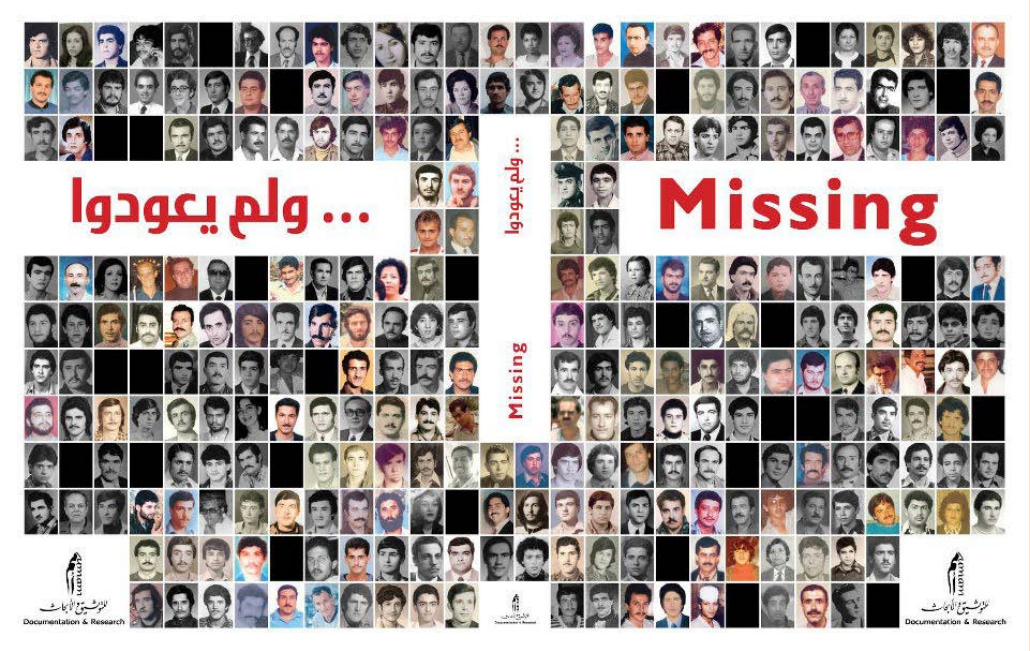
The abiding lack of closure can be profoundly understood through one aged Lebanese father's testimony: "I have not seen my son since he was 16.5" (Interview, Beirut, Lebanon, 2006). The extended loss, despair and disempowerment that families endure in societies where enforced disappearance is a tool of political violence and where silencing opposition appears to be the aim and justice remains absent, present distinct challenges to families, compounding their sense of loss and trauma. Indeed the very crumbling society that betrayed them firstly, betrays the dignity of these families once more through the callous political denial and disregard for their loved ones. These families, indeed, endure a social and psychological life permeated by the disappearance of the loved one.

Robins (2013) usefully describes this state of liminality: "Ambiguous loss occurs where a family member is psychologically present, but physically absent, as for families of the missing or disappeared in conflict or victims of natural disasters" (p. 44). The emotional power of this state of in-between grief, loss and the lure of hope for possible answers that will resolve the engulfing loss of a loved one was powerfully expressed in the protest of one Lebanese mother. On a warm Beirut day, this elderly mother poignantly revealed this paradox. Holding a picture of her son, who was suspected of being detained by Syrian security forces or an allied militia during the course of the civil war, she sobbed, "This is my heart."

A War That Lives On

Families of the disappeared in Lebanon had to challenge a "culture of fear" (Sherry, 1987, 32) concerning the role of Syria and its patrons in the civil war because it was suspected that their loved ones were taken by Syrian security forces and their allied militias present

in the country since 1975. This pervasive sense of fear was a manifestation of three intersecting political dynamics. The state of governance in the country has been such that various Lebanese political actors sought Syrian patronage to sustain their positions during the civil war. In addition, some political/paramilitary actors maintained an ideological allegiance with the regional geopolitical aims of the regime of former Syrian ruler Hafez Al-Assad (Picard, 2002; Traboulsi, 2012). This allegiance to Hafez al-Assad's son's policies, Bashar Al-Assad, for some, has continued. Thirdly, the assassinations in Lebanon of key anti-Syrian figures as well as the dramatic death of Rafiq Hariri by car bomb in the heart of downtown Beirut shocked the Lebanese and the world alike.



Poster produced as part of a social media campaign to highlight the continued disappearance of Lebanese and Palestinians by the UMAM Documentation and Research non-profit organization, Beirut, Lebanon.

The long-standing national sense of heroic martyrdom that detainees or the disappeared allegedly abducted by Israeli security forces have held in the public imagination has further complicated the dynamics of the Lebanese political arena, which these families have contended with for decades (personal interview, 2006). The status of the disappeared, both recognized by successive governments of Lebanon as well as the Lebanese public in general, stood in stark contrast to the isolation and noiselessness which met the fate of the families of the disappeared suspected to be in Syrian jails. Stirrings of a movement by the families of the disappeared, with support from the Lebanese group NGO SOLIDE (translated by the author as Support of Lebanese in Detention and Exile), emerged to challenge this entrenched culture of impunity. During my fieldwork in Lebanon in 2005-2006, Ghazi R. Aad, founder of SOLIDE, explained the chilling effect of the culture of impunity concerning Syria and the impact of their dense security presence in Lebanon had on families of the disappeared: "We broke a wall of silence" (G. Aad, personal communication, 2006).

Aad's campaign began in 1989 in the wake of an Amnesty International-Lebanon effort to engage the fate of the disappeared (Personal interview, 2006). "I received letters from all over Lebanon during this period, up to more than 200 hundred letters," Aad said (Personal interview, 2006). He explained that the culture of silence and impunity that prevailed in the country rendered families afraid to raise the case of their families. Aad's increasingly public efforts led to the establishment of a protest tent at Beirut's famed Khalil Gibran Gardens, which abuts the prominent United Nations Economic and Social Council for Western Asia (ESCWA) in downtown Beirut.

Empowerment and Affiliation

> *"I do my work at night, clean my house. My family says I am gaining nothing, but I say no, I will gain the truth."*
> *- Mother of a disappeared adult son, Beirut, Lebanon (personal interview, 2006)*

The coping and survival of trauma is inherently a psychological, as well as sociological process. Indeed, Judith Herman's (1997) argument for an attunement to the role of empowerment and collective affiliation of survivors of interpersonal and political violence provides us with a salient frame with which to situate the significance of the collective effort of the families of the disappeared. The trauma of these families was assuaged to some degree by the collective campaign of public awareness, the solidarity and connectivity from the bonds of group action such as sit-ins and acts of disruption like blocking traffic in the streets of Beirut. The tent outside ESCWA features placards containing scores of photos of the disappeared alongside the tent. As families, tourists, and visitors walking near the tent in Khalil Gibran Gardens would see, the war for these families had never ended no matter how official the silence around these cases of the disappeared intended to suggest otherwise.

The journey of collective action is not to be romanticized,

Families of the disappeared hold a press conference outside of the tent at Khalil Gibran Gardens, Beirut, Lebanon (Personal interview, 2008).

Families mark the anniversary of their 6th year at the tent in 2010, in spite of the loss a founding mother, tragically killed in a car accident (Photo by SOLIDE, 2010).

however. The year anniversary of using the tent as a locus of their activity and awareness-generating efforts occurred during the course of my fieldwork. The families, including many aged members, remained committed to their ritual of bringing home-cooked food to the tent and sleeping overnight in it, but it left families with a reflective sense that a year had gone by with no change in the status of the families' dearth of information or release of their loved ones and an even more pronounced sense of despair.

Many of the families have endured a long struggle trying to seek information, even paying bribes to Syrian security forces or those claiming to act on their behalf for information, but that provided mostly false or no information (Personal interviews, 2006). From highest echelons of the Syrian government to the lowest rungs of the Syrian state's security apparatus, denial, exploitation and disregard for these families has been its signature approach (see also Salloukh, 2005). For instance, in a visit to Lebanon in 2008, Syrian Foreign Minister Walid Mouallem addressed the families of the disappeared publically stating, "I say to the families of those missing and those detained that he who has been patient for 30 years can wait a bit longer" (Blanchford, 2008).

Despair, Devotion and Defiance Amidst a Region in Crisis

In a recent interview (G. Aad, personal communication, 2015) Aad described the impact of the Arab Spring–a massive political uprising across the Middle East which started in Tunisia and spread to Syria in 2011–the ensuing massive political crisis in Syria, and the effect of its now four-year civil war, on the families of the disappeared. Aad stated that the delicate matter of raising the issue of the long-standing case of the disappeared became ever more labyrinthine, "…with the vast number of the newly detained people in Syria and it is worthy to note here that a special report was presented to the U.N. this year and it spoke about more than 12,000 cases of death in detention at the hands of the security forces…. In short it became almost impossible to access to any kind of information and the issue became, politically speaking, an outdated one" (G. Aad, personal communication, 2015).

These families have tried to continue to find answers in spite of the newly closed doors in the wake of Syria's massive internecine violence, humanitarian crises, and large-scale practice of enforced disappearance. Aad stated, "SOLIDE and the families are still working collectively but the number of family members coming to the sit-in is lesser due to many reasons. Many of the family members… are [now] too old and sick to participate and some died" (G. Aad. Personal communication, 2015). The death of one founding mother was a devastating blow to the families because she was an icon for the group; she had two adult children who disappeared during the course of the Lebanese civil war, and she died after being hit by a car in 2009, on her way to the protest tent..

Time has taken its toll. Aad stated:

> When the war started in Syria the families were optimistic that things might change in a way that would allow them to know the fate of their loved ones but they were disappointed not to say fell into despair because their hope did not materialize. Now they feel more abandoned and that their plight has been forced deep down the list of priorities (G. Aad. Personal communication, 2015).

However, the tent remains pitched at Khalil Gibran Gardens, a place of commemoration to the families and the disappeared, and a symbol of the power of the legacy of collective action by survivors of political violence. This memorialized space remains an embodiment of their determination to persist amidst the vacuum of information and even at times, hope that the cases of these disappeared will be resolved somehow. SOLIDE at present has a draft law before the Lebanese Parliament to establish a national commission on behalf

of the disappeared. Recently, the families achieved a court victory, as well, with their lawsuit against the Government of Lebanon yielding the release to the public of the results of the 2002 official investigation into the matter of the disappeared (El Hassan, 2014).

With enforced disappearance remaining a major source of human rights violations and political violence across the globe, these families in Lebanon continue to teach us that collective empowerment through thoughtful, strategic political action can in some ways provide a means by which to respond to their grief and despair. They forge relationships and collective articulation of their pain while slowly working to transform political cultures of impunity and egregious human rights violations.

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SPECIAL SECTION

Family Lifecycle Stages Under Threat: The Plight of Children Separated From Their Parents

By Ana C. Gardano, Ph.D.

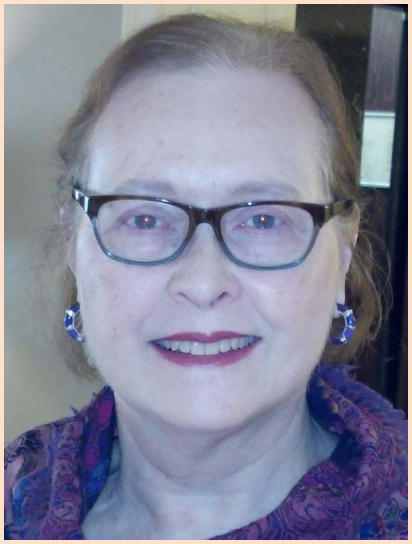
One area of family psychology that has limited research concerns the alarming increase of children and adolescents throughout the world who become separated from their families at different stages of development, most often due to situations such as armed conflicts, political unrest, natural disasters, poverty, death of relatives or parent(s) (UNICEF, 2012). Recent reports indicate that there are 33 million international migrants under the age of 20 in the United States (Abramovich et al., 2011).

In the past few years, the United States has witnessed a marked increase in the migration of children and adolescents who seek better economic opportunities or refuge from civil unrest, gang warfare, or human trafficking (Levinson, 2011). Children and adolescents either travel with family members, leaving their parents behind (separated children), or come on their own (unaccompanied minors). In 2009, just over 6,000 unaccompanied minors qualified for asylum—mostly Central American boys ages 15 to 18—and were placed by the Office of Refugee Resettlement in 43 facilities (Levinson, 2011). During the fiscal year ending in August 2014 (Chishti & Hipsman, 2014), the number of unaccompanied minors apprehended at the U.S. border surged to 66,127, as well as an additional 66,142 parents with children. Most were Central Americans from Honduras, El Salvador and Guatemala, largely due to an increase in drug and gang-related violence. In addition, it should be noted that Central American adults have been migrating to the United States in large numbers since the 1980s. In the case of couples, many left their young children with relatives or friends in the homeland and reunited with them years later in the United States.

For the past 20 years, I have worked as a clinical psychologist conducting therapy with families in the Washington, D.C. area, where 9% of the 3.1 million Central American immigrants live (Stoney & Batalova, 2013). As a Cuban-American, I also became interested in a specific group of Cubans who emigrated under unusual circumstances. As of 2011, there are approximately 2.1 million Cubans and their descendants in the United States (Rosenblum & Hipsman, 2015). This article is largely based on conclusions derived from my intensive therapeutic work with Central American families, my

own exploratory research with Cuban Americans, as well as research literature from various areas of psychology (family life cycle stages, child development, and attachment theories).

Specifically, I focus on the impact of separation of parents from their children and their reunification in adolescence with two different groups: children who are left in the homeland (Central America) when parents emigrate to the United States, and children who emigrate on their own to the United States while their parents remain in the homeland (Cubans). The majority of families I treated from the 1990s to mid-2000 were from El Salvador, Central America, with many of the parents leaving their homeland as young adults to avoid death during the 12-year civil war between government and guerilla forces that ended in 1992 (U.S. Dept. of State, 2011). Couples left their children and relatives in the homeland and singles established their own families in the United States.



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In contrast, the specific Cuban group discussed, mostly consisted of adolescents who left their parents in the homeland and traveled to the United States as unaccompanied minors, between 1960-1962, through a clandestine program labeled 'Pedro Pan' (Walsh, 1971). This program was created shortly after the 1959 revolution due to concerns of Cuban parents regarding changes by the communist system: loss of parental rights, educational indoctrination, and fears that their adolescent activist children would be incarcerated or killed. It was primarily organized by the private schools children attended, along with religious organizations, foreign embassies, and the State Department to provide safe passage (Torres, 2003; Conde, 2001; Walsh, 1971). As middle-aged adults during the 1990's to early 2000, several hundred of the original 14,000 Pedro Pan participants met at several conferences organized to uncover and discuss the impact of this program. I was instrumental in conference content and conducted exploratory research (Gardano, 1993).[1]

In both groups, the children experienced great ordeals in transit to the United States and upon arrival. When Central American adults or children travel by land with guides (coyotes) to the United States, they are at high risk for abuse and trafficking—especially females (Levinson, 2011). For the Cuban group, it was impossible to predict where, with whom, or how they would relocate in the United States. Upon arrival at the airport, children without relatives were first sent to settlement camps in Miami and later relocated to either foster homes or orphanages nationwide (Torres, 2003).

In my opinion, these external circumstances generate a great deal of internal anxiety and insecurity about safety and survival in the children because the parents are not available to protect and guide them. In this sense, the experiences of facing such overwhelming challenges as children are traumatic.

As psychologists, we know that children who separate from their parents for any reason are in a very vulnerable emotional state (Bowlby, 1979). Once there is a lack of the consistency, safety, and security provided by the physical environment and emotional support within their families, children and adolescents are at high risk for a variety of difficulties. I propose that for immigrant or refugee children the rupture of affectional bonds (attachment) between parents and children has long-lasting effects that can be quite traumatic in terms of the establishment of future relationships throughout family lifecycle stages. In terms of individual development, a strong influence is the process of adjustment to the host culture (acculturation). It demands the reorganization of cultural values, which often leads to an ambiguous relationship between the culture of origin and the host culture, and even marginalization (Zagelbaum & Carlson, 2011; Falicov, 2011). In both regards, migration can represent a death and rebirth of the self (Grinberg & Grinberg, 1989) that affects identity development in adolescence.

The psychological impact of separation between children and parents on future relationships is most evident among adolescents in transition to a major family lifecycle stage, Emerging Young Adults, and even later, Couples at Midlife (McGoldrick et al., 2011; Garcia Preto, 2011; Garcia Preto & Blacker, 2011). Attachment theories, mostly initiated by Bowlby (1979) and further developed by others (Allen, 2008) suggest that the process of becoming an autonomous individual—a

[1]At 2 of 3 Pedro Pan conferences, there were presentations about the organization of the program by some of its sponsors (Walsh, 1971), plus time for participants to talk about their own experiences. At the 1993 conference, I invited Dr. Prendes-Lintel to present her research. Participants voluntarily completed a checklist with DSM-IV symptoms of PTSD (30 middle-aged subjects completed the checklists). Prendes-Lintel to present her research. Participants In addition, I trained several mental health professionals to conduct focus groups after the presentations. Focus group leaders used a questionnaire that I prepared related to pre and post migration experiences and family functioning. There were 5 focus groups with a total of 37 subjects. Qualitative information from the focus groups, as well as related research (Suzuki et al, 1998) have been the most relevant findings to the long-term impact of the Pedro Pan experience.

hallmark of adolescence—requires loosening emotional ties to parents that were established throughout childhood. In adolescence, it also involves establishing relationships (attachments) to the individual's peer group and later to a spouse or partner. A delicate attachment to parents remains as they continue in their roles as mentors in subsequent lifecycle stages.

There are several factors that influence transitions into various family lifecycle stages relevant to children separated from their parents: the length of time of the separation, the age of the child at the time of separation and reunification with parents, and the level of support pre- and post-migration. Research suggests that there is a strong relationship between family separations longer than two years and emotional distress (Suarez-Orozco et al, 2011). This research evidenced that Central American children, who were separated at about ages 5–10 and reunited with their parents at ages 9–14, experienced much initial distress upon reunification since they were separated for an average of four years from their mothers and more than four years from their fathers.

The level of distress may be expressed in different ways and is influenced by a variety of circumstances, as I have evidenced in my family practice (Gardano, 1998-2004) and with the Pedro Pan group. Central American children typically separate from their parents at young ages, remain in the homeland, continue contact with parents by phone or short visits, and reunite in the United States with their parents in adolescence (Falicov, 2011; Suarez-Orozco et al, 2011; Gardano, 1998-2004). In terms of attachment theory, unresolved grief over the loss of the parent may be suppressed or denied during childhood (Ainsworth, 1996) and surface as anxiety, anger, and resentment towards their parents upon reunification in adolescence. Thus, the typical, expected rebelliousness towards parental authority may increase to unexpected levels (Suarez-Orozco et al, 2011; Gardano, 1998-2004). At the same time, adolescents experience sadness due to separation from parental figures in the homeland. Often, adolescents may become quite disengaged from parents and seek strong connections with peer groups. Some adolescents may become quite marginalized due to cultural differences and discrimination, and join violent gangs or engage in risky behaviors, such as substance abuse (Gardano, 1998; Gardano, 1998-2004). Others may start their own families in an effort to address the ruptures in attachment to their caretakers (Garcia Preto, 2011). The variety of reactions by adolescents is directly influenced by the quality of their experiences with caretakers in the homeland during childhood and by the parents' ability to deal with the developmental needs of adolescents. Parents may also feel a great deal of guilt and may lack adequate parenting skills. In some cases, adolescents are sent back to the homeland, which increases their perceived rejection by the parents (Suarez-Orozco et al., 2011; Gardano, 1998-2004).

In terms of Cuban adolescents who came as unaccompanied minors through the Pedro Pan program, the impact of the separation from parents was significant throughout subsequent lifecycles, as evidenced by various retrospective studies from this group at midlife (Prendes-Lintel, Suzuki & Leung, 1990) and testimony from conferences (Gardano, 1993). During the initial stages of arrival in the United States, the sudden environmental changes were somewhat alleviated by the parents' coaching prior to departure as well as the support by U.S. sponsors. However, this support did not prevent disruptions in adolescent development (Prendes-Lintel, Suzuki & Leung, 1990). In my opinion, independence from parents was experienced before psychological readiness and not as a transitional process. There was no opportunity to challenge the parents with whom they had established affectional bonds, or to obtain their guidance, as expected in adolescent development. Significant disengagement from parents often resulted from inconsistent communication and the uncertainty about reunification due to censorship and very limited and unsafe migration to the United States.

In essence, it is my impression that the Cuban adolescents either transitioned suddenly into adulthood or regressed to childhood by presumably bonding with new parental figures (e.g. foster parents) after relocation (Gardano, 1993). Some older adolescents emerged into adulthood by quickly acculturating to U.S. culture—living and working on their own to support their education and themselves. This strategy was one way to cope with the many changes. Adolescents who were relocated to foster homes faced a radical change in family configuration and an unfamiliar cultural environment (Gardano, 1993). Parental figures were strangers who spoke a different language and held diverse family values. These adjustment challenges were exacerbated for those relocated to orphanages. In either of these living situations, when parental figures provided secure and positive environmental influences, relative success in adjustment to these changes was reported, with the exception of those who suffered physical and/or sexual abuse (Gardano, 1993).

The length of separation between Cuban unaccompanied minors and their parents was also an important factor that influenced reunification (Prendes-Lintel, Suzuki & Leung, 1990). The average number of years of separation in this study was two-and-a-half to four years. After several years in the United States, disengaged from their parents, many Cuban adolescents had grown into young adults and faced additional developmental challenges when their parents arrived (Gardano, 1993; Suzuki et al, 1998). There was frequently significant ambivalence towards the biological parents, especially if they tried to re-establish their authority. Reunification with parents presented new challenges to those living on their own, or if bonds were established with foster parents. For many adolescents and young adults,

even those who were separated for a short time, a role reversal was manifested by having to financially support their parents and facilitate their adjustment to the new cultural environment. In general, the re-establishment of affectional bonds with biological parents was usually fraught with anxiety, and sometimes, strong resentment for the earlier rupture in their relationship (Gardano, 1993; Suzuki et al, 1998).

As migrant adolescents and young adults transition into the lifecycle stage of establishing their own families (McGoldrick et al, 2011), there are unanswered questions. How did the separation from parents influence their role as spouses and parents? Was the pattern of family separation repeated? Some clues were provided during the conferences with the Cuban Pedro Pan group. Some reported difficulties establishing close spousal relationships, especially in first marriages. Significant anxiety was reported as their own children reached adolescence, as well as during travel away from home or from their children. Qualitative research (Suzuki et al, 1998) revealed that often parents did not discuss their ordeals with their own children. Once uncovered, the children realized the source of their parents' and their own tendencies, such as overprotectiveness and a strong work ethic. In my exploratory research study (Gardano, 1993), symptoms of anxiety and depression were found in most subjects. Those who had never reunited with their parents reported PTSD symptoms, but these may have been related to other experiences.

One of the most striking insights gathered from the middle-aged Cuban Pedro Pan group at the conferences (Gardano, 1993) was that there was a strong need to discuss the circumstances and feelings about their experiences as unaccompanied minors, even after more than 30–40 years since the separation from the parents. It was an opportunity to uncover memories that had been buried for years and to validate their experiences. The conferences served as an appropriate time to discuss and review life's expectations, unrealized dreams, and family relationships—which are essential aspects of the midlife lifecycle. It is no accident that some Pedro Pan Cubans have published books about their experiences at this stage (Eire, 2002, 2010; Neyra, 2010).

The research and information gathered through my clinical work with Central Americans provides evidence for the dramatic influence and complexity of children's separation from, and reunification with, parents during childhood into adolescence and emerging adulthood. In addition, the retrospective information gathered from the experiences of unaccompanied minors from the Cuban Pedro Pan group, now in middle age, provides evidence for the long-term emotional impact on subsequent family lifecycle stages. To help adolescents who have been separated from their parents, I find that it is important to address their own concerns in individual psychotherapy and facilitate communication with their parents in family therapy. At any lifecycle stage, families can greatly benefit from opening up communication about their family separation experiences.

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Children, Trauma and Grief: School Support in Scandinavia

By Atle Dyregrov, Ph.D.

There was little focus on helping children who experienced trauma and loss in Scandanavia until the 1980s. It is not known exactly what caused the change, but hospitals started to address the psychological situation of children who were seriously ill or dying, or who lost a family member (Raundalen, Finne, & Dyregrov, 1981). This was part of an international trend toward more openness regarding death (Bowlby, 1980). In Norway, several programs were initiated in the health care system that focused on children in crisis situations, and psychologists entered pediatric departments for the first time. Early on, we saw in our clinical practice at the pediatric hospital the need for better school responses when a child directly or indirectly was involved in a crisis (or what will now be called a potentially traumatic event). If a child died back in the early eighties, the child's desk would be carried out and no more would be mentioned about this. There were no plans on how the school would care for the students individually or in groups following a critical event.

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By arranging many seminars for teachers across Norway, where teachers were motivated to start crisis groups at each school, pediatric psychologists, including myself, (and clergy who argued for similar attention to children) gradually created a change in the school system. These informal groups were encouraged to arrange half-day seminars at each school addressing how to care for students following events that directly or indirectly affected them. To gain their colleagues' interest, they were told to state that such events could interfere with their ability to study and therefore support was needed. Schools were also asked to develop a plan for different crisis situations that could befell the school, taking into account risk aspects in their particular community. Several of the psychologists involved in being advocates for a change in the school system were also involved in disaster work through UNICEF as well as involved in the disaster planning for the growing oil industry in Norway. In both fields, safety aspects were critical and the use of crisis contingency plans important to secure a proper response.

In 1994, Dyregrov and Raundalen published a book called "Grief and care in schools" (author's translation) that included a chapter by Dyregrov on school emergency plans (Dyregrov, 1994). Dyregrov published the chapter as a small book in Sweden as well (Dyregrov, 1993). In both countries, this stimulated the development of preparedness plans within schools.

While Norway was the first country in Scandinavia to address children's situation and develop psychosocial response systems in the event of disasters (Dyregrov, 1992), a disaster involving a bus with Swedish children

on an excursion in Norway where 14 children and 2 adults were killed, created a momentum towards a change in the caring systems in Sweden (Winje & Ulvik, 1998). They followed along the same lines as Norway and with Sweden's history of establishing structure and systems, they soon surpassed the other Scandinavian countries regarding preparedness. In Finland, the development of crisis intervention in schools started in parallel with Norway as an effort triggered by attention to suicide prevention (Taylor, Kingdom, & Jenkins, 1998). In Denmark, work to improve school response to bereavement originated with the Danish Cancer Society (Bøge & Dige, 1998) while less attention has been given to trauma. More so than in other Scandinavian countries, grief groups are offered throughout Denmark for students and, now, commonly organized at schools.

The changes seen over the last 25 years has been gradual. Today, there are crisis contingency plans in every kindergarten and school throughout Scandinavia as well as within universities. These plans detail what to do, by whom, and at what point after a serious event. The plans cover events that involve one student and events where groups of students or the whole school is involved. However, even though these plans are in place, they do not guarantee that the response will be optimal as knowledge about how to best support students vary between teachers and schools (Dyregrov, Dyregrov, & Idsoe, 2013).

Natural and Mass Disasters

While many outsiders see Scandinavia as a peaceful and safe society, it has been struck with many disasters. With a harsh climate and long coast, Norway has been the country most exposed to disasters while Sweden has experienced the largest event with the sinking of the ship Estonia in 1994 where 852 people died. In addition, in Sweden a discotheque fire killed 63 people, mostly adolescents, in 1998 and the tsunami in 2004 killed 543 people, 140 of them under the age of 18. Finland has had several school shootings, while Denmark has had fewer large disasters.

Colleagues, including myself, have conducted several studies that both document the academic challenges that children and adolescents face (Broberg, Dyregrov, & Lilled, 2005; Dyregrov, Frykholm, Lilled, Broberg, & Holmberg, 2003) as well as how they perceive the support from the school (Dyregrov, Bie Wikander, & Vigerust, 1999; Dyregrov, 2009). The value of early intervention has also been documented (Poijula, Wahlberg, & Dyregrov, 2001), as well as how teachers perceive their role in supporting grieving students (Dyregrov, Dyregrov, & Idsøe, 2013). The extent that preparedness efforts have infused thinking in kindergartens and schools in Scandinavian is reflected by the effort to implement first aid training for preschool children (Bollig, Myklebust, & Østringen, 2011). Dyregrov (2009) studied adolescents who lost a close relative to suicide and documented their increased absenteeism and poorer grades with concentration problems being a main problem. She also found that many students distrusted the school and felt pressure to learn and perform as if nothing had happened. However, many schools offered good support reflecting adequate plans and strategies for handling the students.

A proactive approach has been advocated and initialized by different professionals and institutions both following single-events as well as following mass trauma. After the terror at Utøya in Norway in 2011 where a right wing terrorist killed 69 young people from all over the country, the government launched a national strategy emphasizing teachers' role in dealing with this unprecedented situation (Schultz, Langballe, & Raundalen, 2014). They recommended a practical step-by-step procedure on how to communicate with students, and, later, they made available guidelines for teachers on how to protect students in regard to the lengthy televised trial (Raundalen, Schultz, & Langballe, 2012). Close to 500 students who were at the island survived this attack by fleeing for their life, hiding or swimming away. The government initiated a network for all schools that had students directly involved (bereaved and survivors), and arranged seminars where school leaders from around the country could upgrade their knowledge, discuss good intervention strategies and form personal networks.

Sadly, several school shootings in Finland have provided more knowledge about reactions and appropriate interventions (Turunen, Haravuori, Pihlajamäki, Marttunen, & Punamäki, 2014; Turunen & Punamäki, 2014). Providing outreach acute psychosocial support, psychoeducation and identifying students at risk followed by a group approach to helping, has been part of follow-up programs for students and affected families. Following renovation, the return to school involved symbolic and practical procedures with teachers returning first, supported by professionals, before students returned. They walked through the school in small groups led by their own teacher and accompanied by a crisis worker. Follow-up has continued over the first two years with rituals and remembrance at the anniversaries.

Besides the focus on being able to respond to critical events such as sudden death, accidents and disaster, other forms of trauma has been receiving increased attention in Scandinavian schools. In particular, bullying has been the subject of much research and intervention (Olweus, 2013), lately also tied to PTSD (Idsoe, Dyregrov, & Idsoe, 2012). Olweus' (2013) school based anti-bullying program have spread from Scandinavia throughout the world and its effectiveness is well documented.

While the effects of sexual abuse and violence in the family has received much academic (i.e. Grip, Almqvist,

Axberg, & Broberg, 2013), political and media attention in Scandinavian societies, there has been little attention paid to the effects on schoolwork and the schools' role in supporting affected students.

Conclusion

Although the Scandinavian countries have different histories and cultural traditions, there has been a parallel development of a more caring school climate for children and adolescents who face trauma and loss. Crisis contingency plans that secure that situations are handled in a structured manner by the school are in place. Students will generally meet teachers trained to help them achieve their educational potential in the midst of a crisis. This is not to say that all is well. Teachers still vary too much in their approach, the academic challenges faced by the students remain unmet by systematic efforts to supplement their reduced learning capacity, and while plans may be in place, many students experience that they are not seen over time and that the pressure on them for continuing as before is too high, as we document in a recent publication (Dyregrov, Endsjø, Idsøe, & Dyregrov, 2014). Here teachers and headmasters stress their limited knowledge about how child bereavement affects school performance, concentration and learning, and how this restricts their efforts to support children during the school day. There is not so much rotten "in the state of Denmark," but enough to keep working to better the situation for children who return to school following loss and/or trauma.

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Intergenerational Trauma Among the Aboriginal Peoples in Canada and the Residential School System

By Josephine C. H. Tan, Ph.D.

Aboriginal people in Canada have higher rates of physical and mental health problems, substance abuse, suicide, interpersonal violence, and incarceration than the non-Aboriginal population (National Collaborating Centre for Aboriginal Health, 2012). Many of these mental health and social problems have been traced to their contact with the Europeans that led to their colonization, oppression, and loss of culture (Wesley-Esquimaux & Smolewski, 2004). The attempt by the Canadian government to assimilate the Aboriginal peoples was formalized with the British North America Act in 1867 (Royal Commission on Aboriginal Peoples, 1996), with the government-funded residential school system that was run by various religious orders as one of its assimilation mechanisms (Milloy, 1996). This article describes the trauma legacy left by these schools and how the trauma is transmitted to subsequent generations, affecting an entire society and contributing to modern health and social problems. The article concludes with interventions to address this intergenerational transmission of trauma.

Josephine C. H. Tan, Ph.D.

Residential Schools

The residential school system in Canada was set up in the 1860s, and the last school was shut down in 1996 (Chasonneuve, 2005; Legacy of Hope Foundation, n.d.). In order to attend these residential schools, Aboriginal children were removed from their family and community at a young age (Milloy, 1996). For many, their psychological trauma began with this removal from their homes for reasons unknown to them and continued at the schools, which were run by strangers who did not speak their language and gave harsh punishment for failure to understand or communicate in English. In addition, reminders of their life with their family and cultural identity were removed, including clothes and possessions that came with them. Parent-child contact was prohibited, and siblings also were separated according to gender and not allowed to interact or support one another (Lederman, 1999; Miller, 2012; Milloy, 1996).

While some children were well-treated and received good education in these schools, life for many was exceptionally harsh (Milloy, 1996). These schools were understaffed, underfunded, not well-maintained, structurally unsound, lacked heating in the winter, and altogether unhygienic. There was overcrowding, lack of proper ventilation, poor heating, and tubercular infection among the students (Kelm, 1996; Milloy, 1996; Royal Commission on Aboriginal Peoples, 1996). The children were frequently malnourished or starved, and subjected to physical labour. There were many student deaths in the school due to illness, and some who tried to run away in the winter died from exposure to the elements. More notably, there was widespread physical, psychological, sexual, and spiritual abuse of the students at the hands of the school staff (Royal Commission on Aboriginal Peoples, 1996). The residential schools thus maintained a climate of terror and control over the children for several years. Additionally, by isolating them from their family, community, language, and cultural practices, the children were raised knowing very little about their heritage.

Upon leaving the school, many of the survivors found themselves lacking adequate education (Royal Commission on Aboriginal Peoples, 1996). They ended up living in poverty and continued to suffer from psychological trauma, unresolved grief and anger, lack of trust, depression, and anxiety, and engaged in a number of self-destructive behaviours such as substance abuse and interpersonal violence (Corrado & Cohen, 2003). Not having knowledge of their own culture, they were unable to benefit from the cultural teachings and healing practices that could have affirmed and provided them with positive experiences. The cultural discontinuity also meant that they were unable to develop a strong sense of identification and safety that comes from belonging with any group as they were disenfranchised from their heritage and simultaneously marginalized by the non-Aboriginal society.

Furthermore, the residential school survivors often had difficulty sustaining personal relationships (Menzies, 2007). Their experiences in the residential school system shaped the methods they used to raise children, and several unintentionally took their pain out on their children, family members and friends (Bopp, Bopp, & Lane, 2003). When they used drugs and alcohol or became abusive or violent, their children came to believe these dysfunctional behaviours were normative.

In a community with a large number of families with residential school survivors, the maladaptive behaviours and social problems became commonplace for the collective and subsequent generations, resulting in an inability to address the consequences of the trauma (Menzies, 2007). Oral transmission of information and memories that became part of the collective narrative also contributed to the intergenerational transmission of trauma (Wesley-Esquimaux & Smolewski, 2004).

Responses from the Federal Government

In 1996, the Canadian government called for a public inquiry into the effects of residential school (Royal Commission on Aboriginal Peoples, 1996). Two years later, it established the Aboriginal Healing Foundation to manage a $350 million healing fund over 10 years. In 2005, the Assembly of First Nations launched a class action lawsuit against the Canadian government over the legacy of the residential school. This was settled a year later when the government, representatives of the residential school survivors, the Assembly of First Nations, representatives of the Inuit people, and churches signed the Indian Residential School Settlement Agreement (Aboriginal Affairs and Northern Development Canada, 2012). The agreement included compensation to former residential school students, the availability of a client-centred and non-adversarial out-of-court process intended for the resolution of residential school abuse claims, creation of a public record of the residential school system and its impact, funding for activities to commemorate the residential school students, their families and communities, and funding for healing from the effects of residential school attendance. In 2008, the Prime Minister of Canada, Stephen Harper, offered a formal Statement of Apology to former students of the residential school system (Legacy of Hope, n.d.).

Interventions for Aboriginal Intergenerational Trauma

It is recognized that healing for Aboriginal people must go beyond the individual because of the intergenerational effects of trauma (Lederman, 1999; Urban Society for Aboriginal Youth, YMCA Calgary, & University of Calgary, 2012). In order to achieve this, the Aboriginal Healing Foundation identified three pillars of healing (Archibald, 2006). The first is legacy education to raise awareness of residential school and traumatic experiences so that the trauma is seen as arising from forces outside of the self and not due to the actions of the individual children; this promotes awareness of the trauma backgrounds of their parents and grandparents among younger generations. The second pillar identified interventions to increase cultural awareness and reinforce cultural identity that can facilitate the healing process. The third pillar advocates therapeutic interventions that include culture-safe Western, Aboriginal, or combined psychotherapy approaches.

Western approaches to therapy tend to focus on intrapersonal and interpersonal factors that are psychological, social, and/or biological in nature, while Aboriginal approaches are more holistic and emphasize healthy lifestyles and relationships on an individual and community level, as well as traditional spirituality and healing practices. Implicit in the three pillars approach is the integration of Aboriginal culture into any intervention strategy. Culture is linked to resiliency in that it can offer norms, such as parenting styles that facilitate the development of protective factors and customs and traditions that enhance group identification and self-esteem (Stout & Kipling, 2003). An essential part of the healing process is enhancing the cultural and social status of Aboriginal people as knowledgeable and empowered equals in the Canadian society (Wesley-Esquimaux & Smolewski, 2004). For that to be achieved, health and social problems that arise from historical trauma should be identified as such, rather than inherent shortcomings.

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Promoting the Mental Health of Emergency Service Personnel

By Jane Shakespeare-Finch, Ph.D.

People joining emergency service organisations such as police, ambulance, and fire departments do so because of a desire to assist and protect people in the community, to save lives, and provide a service to people who are often in highly vulnerable and distressed states (Fleming, 2010). Through the course of their work roles, these vital members of our community are exposed to relatively high levels of potentially traumatic events. There has been a burgeoning body of research investigating the effects of emergency service work over the past two decades, with much of it relating to the potentially negative impact of exposure such as the development of PTSD, depression and/or anxiety (e. g., Alexander & Klein, 2001; Regehr, Goldberg, & Hughes, 2002).

Jane Shakespeare-Finch, Ph.D.

However, pathology and other forms of reduced functioning are only a few of the potential outcomes for emergency service workers (ESWs). The vast majority of people working in emergency services, like the broader population, are resilient to the challenges they face (Bonanno, 2005; Pietrantoni, & Prati, 2008), and a substantial proportion of people experience positive changes through the struggle endured in coming to terms with traumatic events (Shakespeare-Finch, Gow, Smith, Embelton & Baird, 2003). The purpose of this article is to highlight the body of evidence which supports the experience of such positive changes, termed posttraumatic growth (PTG; Tedeschi & Calhoun, 1995; 1996; 2006). Posttraumatic growth can follow even the most adverse experiences negotiated by emergency personnel, and has implications for the ways in which organisations may promote and maintain their employees' mental health. Other indices of mental health, rather than ill-health, are also discussed.

The first paper that explicitly sought to document the prevalence of PTG in an ESW population was published in 2003 (Shakespeare-Finch et al.). In a sample of 526 ambulance officers, more than half of the sample reported moderate levels of positive changes and nearly a quarter reported PTG changes to a high degree. Only 1.4% of participants said they had experienced no positive changes following their experiences of trauma. Armstrong (2014) led a research project that examined mental health in fire and rescue personnel. Consistent with the research investigating PTG in paramedics, PTG was found to be much more prevalent than symptoms of PTSD, or other forms distress (depression & anxiety).

Personality variables like extraversion and openness to experience have been found to predict PTG in paramedics, but the relationship appears to be mediated by various coping strategies. For example, Shakespeare-Finch et al. (2005) found that there was a positive relationship between personality dimensions and PTG, but that coping strategies accounted for much more variance (44%) in PTG scores than all of the big-five personality dimensions combined. It may be intuitive to propose that the coping strategies that predict growth would have an inverse relationship with PTSD and other negative post-trauma sequale. However, in a study examining coping strategies as predictors of PTSD and PTG in paramedics, different coping strategies predicted these two outcomes rather than high levels of a strategy that predicted growth having an inverse relationship with PTSD symptoms (Kirby, Shakespeare-Finch & Palk, 2011). Consistently, Armstrong et al. (2014) found that self-care as a coping strategy predicated PTG in fire-fighters but not symptoms of PTSD, whereas work-related

cognitive reappraisals were predictive of PTSD and not of PTG. One implication arising from these results is that programs that aim to promote PTG in emergency service workers as well as decrease PTSD need to include a broad repertoire of coping strategies – those that decrease symptoms of PTSD as well as strategies that promote PTG.

In a prospective study of a resilience building intervention, Shochet and colleagues (2011) worked with a police department using a community participatory research design to develop a program for new recruits aimed at providing psychological skills and resources that they could draw on to deal with potential trauma. The intervention, among other things, included information and exercises about PTG. Data from a randomised control trial collected pre and post intervention (three time points) demonstrated higher levels of growth in police recruits who were in the intervention group that those who were in the usual psycho-education program (Shakespeare-Finch et al., 2014a).

Examining professional quality of life in a sample of 961 first responders in Africa, Pietrantoni and Prati (2008) found high levels of compassion satisfaction and very low levels of burnout and secondary traumatic stress. A very similar picture was painted in Australia in a study with 1042 ambulance personnel (Shakespeare-Finch, Wehr, Kaiplinger, & Daley, 2014). In this research only .03% of participants reported clinical levels of burnout and secondary traumatic stress, with nearly 98% of the sample reporting moderate or high levels of compassion satisfaction. Figure 1 depicts these findings. Perceptions of organisational connectedness (feeling valued, respected, a sense of belonging) was the single biggest predictor of mental health and ill-health. Results from these two studies demonstrated that these emergency service workers reported lower levels of negative sequale and higher levels of compassion satisfaction that is found in the general population.

One of the implications of the above research applies to the psycho-education and intervention programs that many services offer to new recruits and seasoned officers. From my experience attending these trainings, some services have an hour of psychological preparation for active duty that primarily include contact information for staff support, some warnings about the potential for distress and symptoms of PTSD, while others aim to normalise the initial reactions to traumatic events. However, emergency service organisations can do so much more to assist their staff in maintaining and promoting mental health.

One organisation that has embraced a comprehensive staff support and psycho-education service has extremely low levels of psychological injury in their ranks (Scully, 2011). Two multiple-method evaluations of the service, 10 years apart, provided additional data to support this claim (Shakespeare-Finch & Scully, 2004; Shakespeare-Finch et al., 2014b). But can one service be held up as an example of training and staff support that promotes mental health? Perhaps it can. Indeed, this particular program has been so widely acknowledged as the gold star of staff support services, it has been adopted in other countries, such as the United Kingdom (Scully, 2006). The below figure depicts this comprehensive staff support service. In the diagram PSO refers to trained peer support officers, EMD to emergency medical dispatches, PTO to patient transport officers, LASN refers to a particular geographical region, and 1800 no.

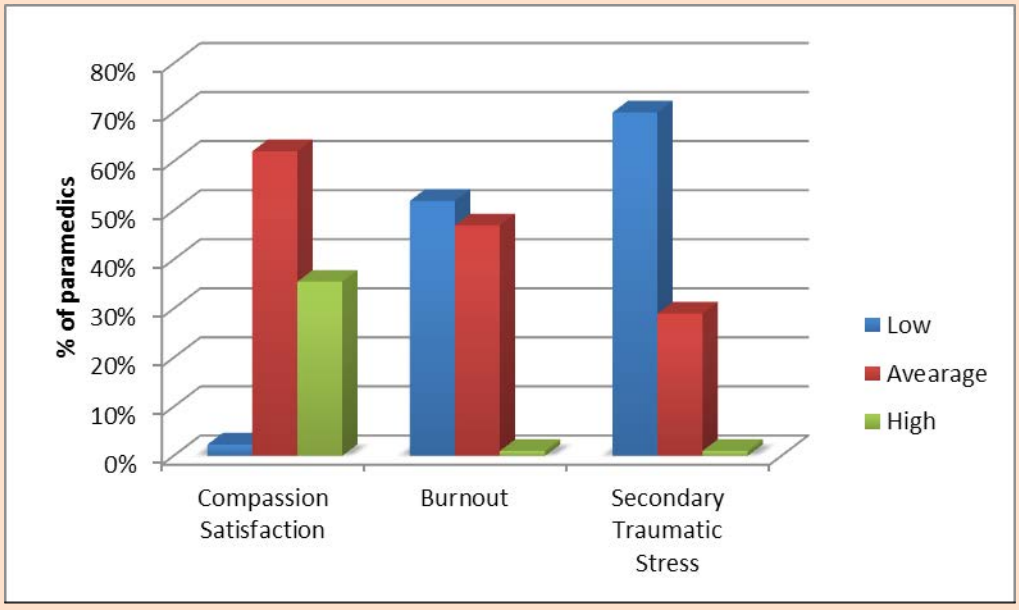
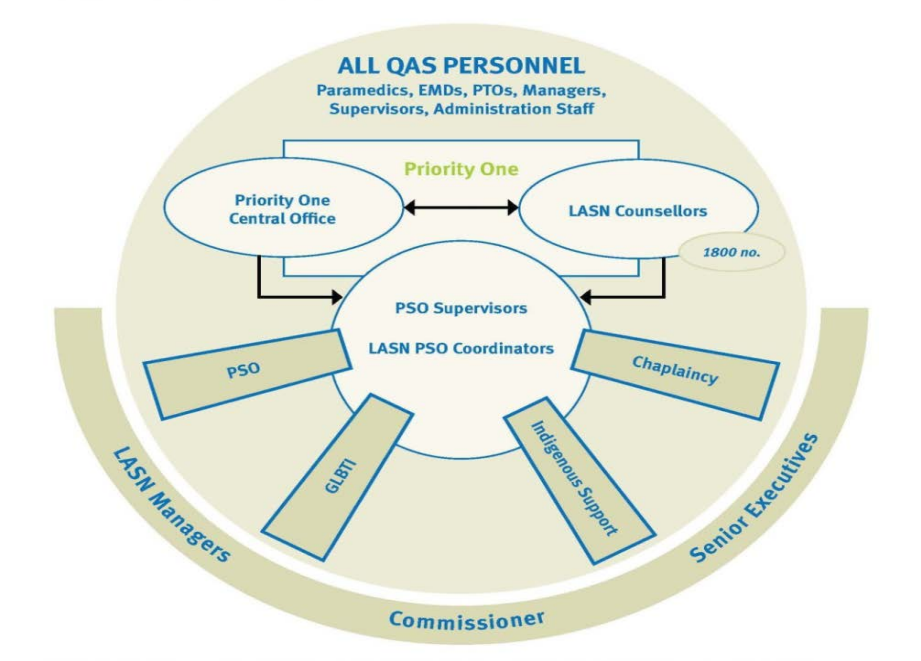


Figure 1. Percentage of paramedics with low, average and high levels of compassion satisfaction, burnout and secondary traumatic stress.



refers to a 24 hours telephone counselling line.

As can been seen in this article, many self-citations have been used. This is not a self-serving strategy, but rather a reflection of the paucity of research in this area when the goal is to identify positive post-trauma changes and factors that may promote such changes. ESWs are an integral part of many societies and the promotion of their mental health is important for them, their families, the organisations they work for, and the community in general. More research is required cross-nationally and with more complex research designs to continue to identify the most effective ways to prepare and support personnel. A focus only on the pathology that may be experienced as a result of this kind of work does not necessarily identify ways in which PTG, resilience, and other positive outcomes can be promoted. The nature of emergency service work cannot be changed; employees will continue to be exposed to relatively high levels of potentially traumatic experiences. However, what can be changed is the way in which organisations support their staff, psychologically prepare new recruits for what lies ahead, and create workplace practices that engender a sense of connectedness with the organisations for whom they work.

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The War That Never Ends: The Israeli Experience of Traumatized Israeli Veterans

By Zahava Solomon, Ph.D., and Liat Itzhaky, Ph.D.

In its 67 years of statehood, Israel has known seven full-fledged wars, several large-scale military operations, and innumerable acts of terror (Bregman, 2010). War is the ultimate human aggression. Combatants are naturally the ones most severely exposed. In constant danger themselves, they witness injury, the death of friends and enemies, and are exposed to gruesome sights and sounds of slaughter. At the same time, combatants are expected to inflict death and injury on the enemy, often combatants, but at times civilians. These combat stressors are bound to give rise to anxiety, a perfectly normal response to imminent threat (American Psychiatric Association, 2013). The vast majority of combatants remain psychologically intact despite the considerable stressors of war and overwhelming destruction of modern warfare (e.g. Booth-Kewley et al., 2013). In this article, we present highlights of several longitudinal studies attesting to the heavy toll of war on Israeli combatants.

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Combat Stress Reaction

A small, although not insignificant, percentage of combatants are overwhelmed by anxiety (Solomon, 1993). They perceive the threat as intense, prolonged, and uncontrollable and feel completely vulnerable and powerless. They thereby experience a psychological breakdown known as "combat stress reaction" (CSR), "shell shock," among other terms –a particular subtype of Acute Stress Disorder (ASD) (Solomon, 1993). CSR occurs when combatants are stripped of psychological defenses and feel so overwhelmed by the threat that they become powerless to counteract or distance themselves. As a result, combatants are inundated by feelings of helplessness and anxiety. In this state, they are a danger to themselves and others and no longer able to perform military duties (Kormos, 1978).

The prevailing definition of CSR is functional, rather than clinical. Despite its seemingly simple definition, CSR is extremely difficult to identify (Solomon, 1993). This is likely due to the large range of polymorphic and labile symptoms that characterize CSR, including a variety of psychosomatic, cognitive, emotional symptoms and behaviors (i.e., paralyzing anxiety and deep depression). The rapid alteration of symptoms can be quite perplexing to the observer. In the chaotic and abnormal context of the battlefield, combatants' behavior is generally disorganized and not reflective of their everyday life. Moreover, those who could make the identification – the afflicted soldiers, commanders, and fellow comrades – are themselves caught up in the stress of the situation, and their judgment is unreliable. As a result it is assumed that the recorded prevalence of CSR is often underestimated.

From Combat Stress Reaction to PTSD

CSR can be a transient episode for some, while for others it marks the beginning of profound and prolonged psychological and somatic sequelae of posttraumatic stress disorder (PTSD) and/or other co-morbid conditions (Solomon & Mikulincer, 2006). For instance, Solomon and colleagues (1993; Solomon

& Mikulincer, 2006) initiated a 20-year follow-up study of identified and treated Israeli CSR casualties of the 1982 Lebanon war. Their findings clearly demonstrated that for many traumatized combatants, psychological breakdown on the battlefield marked the beginning of a lifetime of distress and impairment. It was revealed that 64% of identified CSR casualties suffered from PTSD one year later. At two years, the rate of PTSD decreased to 59% and then decreased further to 40% at 3 years. Surprisingly PTSD rates increased again to 53% twenty years after the war in those studies. In other words, the war does not end for many traumatized veterans, because CSR marks the beginning of a life-long vulnerability (Solomon & Mikulincer, 2006).

Combat-induced PTSD also emerges among veterans who have not sustained CSR on the battlefield (Solomon & Mikulincer, 2006). Interestingly, 14% of veterans who served as a control group in the Solomon and Mikulincer study (2006) participated in the Lebanon War but did not experience psychological breakdown on the battlefield, yet suffered from PTSD during the first year after the war: 22% during the second year, 11% during the third year, and 27% twenty years after the war. These figures point to a detrimental impact of war, even on combatants who survive the immediate stress of combat without a noticeable breakdown.

The high PTSD rates in both groups are intriguing. Clearly, they reflect the deep wounds that CSR entails. However, in the Israeli context the high rates may well reflect the continuing threat of war and terror. All of our participants, like other Israeli men of their age, have served in Israel's reserve forces and could have been recalled at any point for active duty (Solomon, 1993). Given the ongoing geo-political conflict, they have also been repeatedly subjected to the threat of terror and continue to be exposed to vast military stimuli (Solomon, 1993). Such exposure may well have impeded their recovery from trauma.

The last assessment of this study was conducted during the second Intifada, a period of escalation of the Israeli-Palestinian conflict accompanied by numerous acts of terror. Possibly, the vast exposure of these veterans to harsh political violence re-activated the initial trauma.

Psychiatric and somatic comorbidity

Our studies revealed that posttraumatic residues among Israeli veterans were not limited to PTSD (Ginzburg, Ein-Dor, & Solomon, 2010). Longitudinal assessment of the Lebanon War veterans indicated that, as in similar cases (e.g., Kulka at al., 1990), PTSD is unlikely to appear as a sole diagnosis. Indeed, 74-80% of Israeli veterans with PTSD also endorsed co-morbid anxiety or depression or both (Ginzburg, Ein-Dor, & Solomon, 2010).

Moreover, the long-term implications of war expand beyond the psychological, and into the physical in our research. At all points of assessments conducted among the same veterans over 20-years (Benyamini & Solomon, 2005; Ohry et al., 1994), CSR and PTSD were associated with lower self-rated health, chronic diseases and physical symptoms, as well as greater engagement in health related risk-behaviors, such as smoking and alcohol consumption.

Many PTSD symptoms (i.e., avoidance, poor concentration, irritability) were implicated in later functional impairment. Our longitudinal prospective studies of Israeli veterans of both the 1973 Yom Kippur war and Lebanon War uncovered considerable difficulties and impaired functioning in work, families and social life (i.e., Neria et al., 2000; Solomon, Debby-Aharon, Zerach, & Horesh, 2011).

The Home Front

Most of the studies (e.g. Levy & Sidel, 2008) on the short and long-term sequelae of combat were conducted in the United States, Europe and Australia, where combatants are often active in conflict zones that are geographically removed from "home," and thus at the end of their service, usually return to war-free civilian society. In Israel, after completing three years of compulsory military service, all able-body Israeli men are required to serve in the Israel Defense Forces (IDF) reserves until the age of 45. Therefore they continue to be directly exposed to military stimuli.

Repeated Exposure to Combat

Several theoretical models depict the effect of repeated exposure. The vulnerability perspective (Coleman, Burcher & Carson, 1980) considers repeated exposure to stressful events to be a risk factor, since it affects an individual's coping resources, thereby increasing vulnerability. The stress inoculation perspective (Epstein, 1983) holds that repeated stress serves as an "immunizer" in that it fosters the development of effective coping strategies and promotes adaptation. The third view, the stress resolution hypothesis, postulates that what matters is not the mere exposure to stress, but the outcome of the earlier stressful experience (Block & Zautra, 1981). According to Block and Zautra (1981), successful coping leads to a feeling of well-being and an increase in coping ability, while unsuccessful coping leads to increased distress and decreased coping ability.

Solomon, Mikulincer and Jacob (1987) examined the effects of repeated exposure and compared veteran groups. In their study, they found that the highest CSR rates in veterans from the Lebanon War were among those who had a prior stress reaction in a previous war (66%), lowest among those who fought previously without CSR (44%), and in between among veterans with no prior war experience (57%). These figures suggest that the successful resolution of previous stress

helps soldiers to cope with subsequent combat. However, they also indicate that novice soldiers are better off than those who experienced an unresolved breakdown in a prior war. Although not every soldier who sustains CSR is doomed to a second breakdown under similar circumstances, our findings suggest that CSR leaves most combatants more vulnerable the second time around.

Reactivation

One of the phenomenon characteristic of combat-related PTSD involves reactivation of previous CSR after exposure to subsequent stressors (Solomon, Garb, Bleich, & Grupper, 1987). The reactivation spectrum ranges in severity from very mild to extreme behavioral and functional disability.

Uncomplicated Reactivations or Classic Reactivations. Veterans that seemed to have completely recovered from CSR in a previous war, and were virtually symptom-free between the wars, had a reactivation that was reminiscent of previous war traumatic experience (Solomon et al., 1987).

While classical reactivation was observed in a minority of cases, the majority (75%) of the reactivated cases in our study are more aptly termed *exacerbated PTSD* (Solomon et al., 1987). Here the earlier stress reaction left more visible residuals, and the veterans continued to suffer from PTSD symptoms of varying severity. Symptoms became intensified during a subsequent war. The exacerbated PTSD cases can be subdivided into three groups:

Heightened Vulnerability (51%) consists of men that, following their past war exposure, suffered from mild, diffuse PTSD symptoms, which did not interfere with their day-to-day functioning and from heightened sensitivity to military stimuli (Solomon et al., 1987). Their residual or sub-clinical PTSD developed into a full-blown syndrome when they were exposed to a subsequent direct military threat, often similar to the trauma, which had provoked their initial breakdowns.

Moderate Generalized Sensitivity. Following an initial breakdown in a previous war these veterans had generalized sensitivity in their civilian and military lives (i.e., sleep disturbances, nightmares, irritability), which somewhat impaired their functioning. When exposed to a second war these men soon developed CSR in response to relatively minor military stimuli.

Severe Generalized Sensitivity. These veterans suffered from severe generalized sensitivity throughout the entire inter-war period. For these veterans, the mere arrival of the call-up order to war brought on an immediate and severe stress reaction. Many had this reaction at just the thought of returning to combat.

In all these cases, the second reaction revealed the psychological damage that the first had created and then deepened it. In general, there were more symptoms following the second reaction than the first, and the symptoms were more intense and debilitating (Solomon, Oppenheimer, Elizur, & Waysman, 1990). Furthermore, even though some soldiers participated in battle after a CSR episode without further breakdown, the detrimental effects of the earlier episode were still detectable a decade later (Solomon, 1993).

Delayed Onset PTSD

The manifestations of trauma sometimes are, or seem to be, delayed (Andreasen, 2004). Delayed-onset PTSD occurs when an individual first appears to respond adaptively to traumatic stress, but then develops psychopathology after an asymptomatic latency period. This issue raised a considerable amount of interest and became controversial over the years (see Andrews, Brewin, Philpott, & Stewart, 2007). Delayed PTSD was described among veterans in many wars (e.g. World War II; Archibald & Tuddenham, 1965). Yet it became a major issue after the Vietnam War (Laufer et al., 1984). In the years that followed that war, the steadily growing numbers of veterans with war-related distress became a major public health problem.

The authors recently examined veterans from the Lebanon War over 20 years after the war and found a rate of 15% delayed-onset PTSD (Horesh, Solomon, Keinan, & Ein-Dor, 2012). In a series of studies, we also explored the correlates of delayed PTSD, attempting to cast light on the underlying mechanisms responsible for the delay in symptom onset. Veterans with delayed-onset PTSD had more personal (i.e., locus of control) and social (i.e., social support) resources compared to veterans who experienced a more acute reaction. In addition, veterans with delayed-onset PTSD both three years and 20 years after the war presented a less severe clinical picture than those with "regular," non-delayed PTSD (e.g. Solomon, Mikulincer, Waysman, & Marlowe, 1991; Horesh et al., 2012). Thus, it may be concluded from these findings that the delay in symptom onset among these Israeli veterans is a sign of relative psychological resilience.

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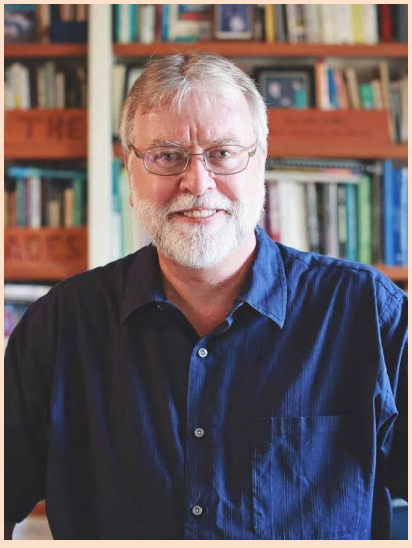
Conversational Trauma Counseling: Examples from Africa, Asia, and the Middle East

By George F. Rhoades, Jr., Ph.D.

"Conversational Trauma Counseling" is a trauma counseling technique that I have developed after conducting humanitarian missions to deal with man-made and natural disasters in over 28 countries in the Pacific Basin, Asia, Africa, Middle East, Europe, South America and North America (Rhoades, 2014).

The various host countries choose local leaders and professionals (pastors, police officers, medical personnel, government officials, counselors, social workers, psychologists, and psychiatrists) to receive training over a 3–5 day period that involves the practical application of the training in Internally Displaced Persons (IDP) and Refugee camps and then supervision of this experience. The training involves presentations on psychological first aid and then an introduction to trauma counseling, namely "Conversational Trauma Counseling," emphasizing that each session is important as it could be the only session with that person. Additional time is allotted for specific issues that the community identifies and needs to address with leaders before or after the particular



George F. Rhoades, Jr., Ph.D.

disaster.

In a conversational format, the participants are taught how to develop rapport more rapidly with survivors, honor those that were lost and the traumas experienced. The sharing of the survivors' personal stories is encouraged and the problems/challenges experienced due to the disaster are discussed. The person then is guided on how to problem-solve one of these issues and to develop an action plan to take some control back into their lives. It is important to leave positive encouragement or a message with the survivor as typically there is no opportunity for a second session. These techniques are demonstrated to the leaders by myself and volunteers from the audience.

Southern Sudan was the site of many of these trainings for leaders in and around IDP camps after the decades old civil war with Northern Sudan and the resulting devastation and famine (Government of the Republic of South Sudan, 2014). One leader/trainee shared her story of seeing a young woman crying outside of her mud hut in an IDP camp. Through conversational counseling, she learned that the woman was pregnant and had two other small children; her husband had left weeks earlier to find work in another part of the country and had not returned: "The woman had no more food left and rather than dying from starvation, considered suicide. She had broken glass on her table with the intent of having her children and then her drinking the glass to die." The recently trained leader was able to encourage the young woman that she was not alone and that there was hope for the future." The young woman did not commit suicide and agreed to meet the leader later that week. The next day, the husband returned and reported that he had found a job in another part of the country. One could only imagine the tragedy of finding the bodies of his wife and children if the events of the day before had not occurred.

When I came to Sri Lanka after the terrible deadly South East Asia tsunami of 2004, the devastation of the loss of over 40,000 persons in minutes was overwhelming to the survivors and other relief workers. Our philosophy is to work with governments and the local community leaders, so we met with the deputy director of health who gave us permission to work in the IDP camps. Travelling to Galle over several hours involved going through towns with gutted homes and businesses and seeing the remains of boats and other objects scattered throughout the landscape. We were sent to a building that was the temporary residence of the Department of Health's response to the disaster. We walked in to hear the deputy director shouting, "Counseling—no one talk to me about counseling!" The gentleman was yelling at doctors gathered to discuss responses to the disaster. After receiving my business card, however, the deputy met with me privately to discuss what we needed to do to provide trauma counseling at the IDP camps. He asked us to not tell

anyone about what we were doing."as he was now agreeing to support the very counseling that he had just denounced to his group of doctors."

We went into an IDP camp close by, bringing along several government officials in their white shirts and ties. It was obvious that this was their first visit to the camp, and it provided a time of sharing between the survivors and the government officials. Meeting with the camp leader, he shared that his teenage daughter was ripped from his arms in the terrible waves of the tsunami. He later found her dead in the mud and when he cleaned her up, he brought her to a standing hospital, but they refused to release her body and he has never been able to grieve fully because he could not arrange for a funeral/burial service. Conversational counseling allowed many to share their stories, to begin problem-solving, and to look toward the future. The camp leader invited me to return for the memorial service for his daughter when it occurred. Ten years later, there is still no contact: sadly, there is no apparent chance to do a memorial service in their culture without a body. Tears still come to my eyes when I think of that moment and his story.

A recent trip to Lebanon allowed me to work with a couple of leaders from Syria. They were both residents of Damascus, and IDP persons from other parts of Syria—crossing the borders—showed their dedication to come to the trauma training. I heard many stories of government forces, different groups of rebels, and the frequent murders by beheadings of all the aforementioned groups. They reported that returning to Syria could now be risky as they could be forced into the Syrian Army if they were of age and male even if they had served before in the military. Working from 8 a.m. till 11 p.m. for three days left me exhausted to the point that I did not hear a night of missiles, bombings, and gunfire only three miles away in Syria. My exhaustion was nothing compared to the horror of those that now had to return to the war-torn country.

One woman shared how she held on to anger at her father for going to visit a relative in another part of Syria before the civil war. As he went to visit the relative, he was killed in a head-on collision. She is now almost paralyzed in making decisions because she feels her decisions may also lead to similar traumatic results. The "Conversational Trauma Counseling" in front of the group helped her, in her capacity as a leader, to recognize that she had made some rather good decisions since the death of her father and that she no longer needed to focus on what she believed to be a bad decision, but could celebrate who her father was and then begin to truly grieve

This demonstration shows that in many traumatic situations, a person still needs to deal with past issues that also impinge on the present and future. This is why we often address other issues important to the groups besides the obvious trauma experienced in the disasters: Parenting in Southern Sudan (Now South Sudan), Sexual Trafficking in Philippines, Dysfunctional Adult Children in China, Street Children in Paraguay, Sexual Abuse in Tahiti and so forth. I have been invited to go into Syria to continue the training.

Having done trainings with the country of Paraguay in 2007, "Conversational Trauma Counseling" is a culturally sensitive training program available for small groups, communities, and countries. The process involves training leaders of a given country to help their citizens cope with both man-made and natural disasters. The training is practical, and designed to make the biggest impact in counseling, which is often limited to one session in these situations. There are opportunities for more therapists and interns to be involved in short-term humanitarian missions, typically lasting 10 days (three days travel and seven days on the ground). For more information on this humanitarian work, please check out www.roadstohope.org or email me directly at dr.grhoades@gmail.com.

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Developing International Collaborations for Early Career Researchers in Trauma Psychology

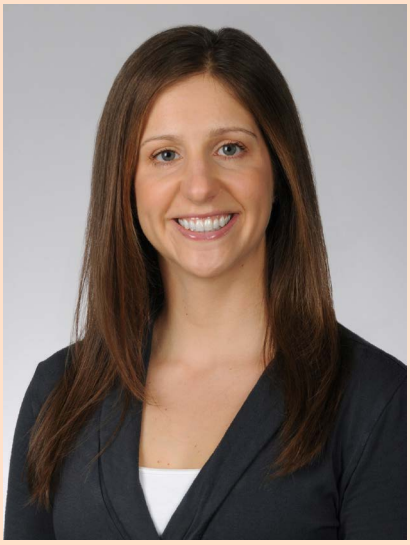
By Julianne C. Flanagan, Ph.D., and Emma L. Barrett, Ph.D.

Perhaps the most fundamental task facing early career psychologists is to cultivate a program of research that is not only fulfilling, but clinically and scientifically impactful. For those of us who choose to pursue careers in an academic setting, the necessity of articulating the impact of our work is emphasized early and often. We learn to express our trajectory on paper, and to explain the ways in which our work is cohesive and purposeful. Most importantly, we must communicate how our work has facilitated scientific growth in our chosen area of study. Early career psychologists (ECPs) focused on research complete this task through applications for fellowships, career development awards, in the National Institutes of Health's (NIH) new biosketch format, and, most commonly, in the preparation of promotion packets. However, one aspect of professional and research development that some ECPs might not be aware of is the availability and value of considering international collaborations. The authors, housed at academic institutions in the U.S. and Australia, have developed an enjoyable and productive international collaboration. The aim of this article is to describe the role of international collaboration in professional and research development for ECPs and methods that we have used to develop our relationships and our projects.

For most of us, evaluations of the impact of our work hinges on the extent to which we are progressing toward a position of nationally-recognized expertise in our chosen area of study. That expertise is typically evidenced through scholarly productivity in the form of internal and extramural funding, publication in peer-review outlets, and presentation at national conferences. For many of us, the rigor of the evaluative process, particularly with regard to attaining extramural funding and preparing for promotion, has expanded to also necessitate demonstration of *international* recognition. In order to be recognized internationally, one might attend international conferences and/or work in collaboration with researchers abroad.

We are all familiar with the vast benefits of collaboration. The same benefits apply to examining research questions in the field of trauma psychology internationally. Trauma psychology is strongly influenced by vast differences in current events, politics, culture, and language, that it must be examined both

within and between cultures; international collaboration can greatly facilitate those efforts. Like the authors not long ago, ECPs may believe expanding their program of research internationally is out of reach, and something to be considered only by more senior, accomplished, or known investigators. Over the past two years, each of the authors gathered our courage with the support of our respective mentorship teams and tested that hypothesis. Once we identified a mutual interest in collaborating, we began working together on the development of appliations to support . Our findings suggest that, in fact, an interrnational collaboration between early career investigators is not only feasible, but extremely rewarding.



Julianne C. Flanagan, Ph.D.

Our collaboration has increased our professional confidence and autonomy, the quality of the conceptual foundations for our research questions are enhanced, and we think of ideas that neither of us would have come up with independently. Successful international collaboration suggests that you are working independently and productively. Perhaps most importantly, we have fun exchanging ideas and sharing in one another's accolades and challenges. We have become peer mentors and friends as well as colleagues. We aim to share our experiences with you and hope that you are encouraged to consider pursuing your own international collaborations.

Emma L. Barrett, Ph.D.

Getting Started

Choose Wisely

As with any professional or personal partnership, carefully choosing one or more partners to work with is essential. Consider which groups of investigators work in your area. Among them, which individuals have written recent publications that caught your attention as being particularly novel, interesting, or congruent with your own trajectory? The co-authors are members of a small community of researchers interested in examining the overlap between posttraumatic stress, substance use disorders, and interpersonal violence. We knew of and admired each other's publications before we made contact, and that has provided an important foundation of confidence in one another's skills. One critical component in choosing a collaborator is finding someone who has a well-established ability to write effectively and efficiently. Similarly critical is finding someone who has demonstrated a strong capability of transitioning projects from preliminary ideas to implementation to dissemination. Someone who has limited experience with the regulatory processes at their institution, research design and data collection, or who has limited writing experience may not be the most effective international collaborator.

Make Contact

Once you have an individual or group in mind, it is time to connect. This process is no different than that which you might have used to connect with potential graduate school mentors, internship faculty, or faculty at the sites where you apply to fellowship or for employment. We, the co-authors, were fortunate that our respective research teams, and our individual mentors in particular, had an ongoing and effective collaboration. For this reason, it is useful to keep in mind the international links that your mentors or research team have already established when considering potential collaborators. While our initial email contact had some context, we had never communicated directly before and it still required some courage. In the absence of an individual who can provide a letter of introduction, compose one for yourself that explains briefly the focus of your program of research, the fact that you have been following this individual/group's body work, and that you'd like to become acquainted and possibly to consider future collaboration. Press send.

Start Small

As you have no doubt experienced, not every collaboration will grow to be long-lasting and some are more fruitful than others. The extent to which you will reap reward from and become invested in your international collaboration is dependent on a variety of individual and environmental factors. Like any partnership, beginning with small steps and gradually increasing investment is an effective strategy. Once we, the co-authors, established a mutual interest in collaborating, we met via skype. The use of video conferencing has been invaluable as it not only demonstrates a commitment to the partnership, but it also lends a greater sense of "realness" to the collaboration. We began by establishing the topics of interest we had in common, the other commitments we had at that time, and how those would evolve in the coming months.

Excellent starting points are to co-author a poster submission. Determine if you will be attending any of the same professional meetings and consider putting together a symposium. Manuscripts are also a wise choice. We may have made a small misstep in beginning a meta-analysis together (one which encapsulated our mutual interests extremely well) rather than beginning with a more straightforward paper, and it remains in progress. Since then, we have co-authored more than one paper together (including this one), and have included additional measures in one another's ongoing studies to facilitate co-authored papers in the future. Having these experiences under our belt has made it easier to begin planning new data collection together.

Communicate

The more clearly, the better. We have found that effective communication not only facilitates our productivity, but also increases our professional autonomy. Psychology training models typically rely heavily on mentorship. Regardless of how much autonomy one has with their primary mentors, we usually work through them in a variety of ways. With international collaboration, we have found that we are challenged to refocus on the topics that genuinely excite us and are the most fundable, not just what happens to be most readily available. Our collaboration has also challenged us to be more selective with the endeavors we commit to at our respective institutions because we have an additional source of productivity. Further, it has challenged us to be more assertive when an aspect of the project planning or collaboration is not meeting our needs well, and we adapt. These experiences are invaluable as we grow more independent and become increasingly self-reliant at our respective institutions. It has also proven useful and heavily reinforcing to express to one another our appreciation for one another's work on shared projects as well as our partnership generally.

Anticipate Challenges

Perhaps the most substantial obstacles we have encountered result from 1) differences in institution closures and holiday schedules (our seasons are opposite, after all); 2) time zone differences; and 3) navigating regulatory approval processes across institutions. Overcoming each of these issues requires careful planning, otherwise it is easy to lose momentum or grow resentful of perceived differences in commitment or work output. There is little to be done with regard to the first and second issues, aside from careful planning and communication. For example, in order to meet, Dr. Flanagan stays at work late while Dr. Barrett arrives early. Due to the aforementioned meta-analysis challenge, we know that certain times of year are not effective to begin projects and that we need to avoid scheduling some activities during critical periods when one of us is working and the other is on holiday. We schedule skype meetings at least once quarterly. We continue to navigate regulatory issues by sharing materials from our previous submissions and asking for assistance from senior investigators who have had success managing similar challenges. Importantly, we expect that other challenges will arise over time and we share a willingness to navigate them when they arise.

Authorship and Leadership

While we have not encountered difficulties with navigating leadership and authorship among ourselves, we recognize that is an important concern in all collaborations. We urge you to avoid agreeing to any arrangement that you feel uncomfortable with; allow yourself adequate time to think arrangements over before agreeing or proposing alternatives. Most importantly, plan ahead during the exchange of ideas. If it is important to you to lead a particular paper or project, make it known. Inherent to this process is a shared belief we expressed to one another that each of us not only wants the other to be as successful individually as they can be, but that at every turn our behaviors bolster the best interest of the collaboration.

Name It

We received this critical piece of advice from a senior colleague. Putting a title to your collaboration makes it more concrete and provides you with a name to use on paper. We decided to call ourselves an international consortium and build a website. This "organization" is comprised of little other than a handful of colleagues who have agreed to be tied together with this title and a mission statement, but someday, it might provide the basis for funding opportunities such as a large-scale center grant. Dr. Flanagan was also invited, in a very informal process, to join the National Health and Medical Research Council-funded Centre of Research Excellence in Mental Health and Substance Use (CREMS) as an associate member. U.S. researchers often think of affiliations as the organization(s) from where your paycheck comes, but determining if there is an informal title to assign yourself and your colleagues within your working institutions is a simple way to indicate your collaboration on your CV and application.

Travel

If your personal life and funding situation allows, apply for opportunities to travel to enhance your collaborative relationship. Nothing says, "I'm willing and invested" like physically traveling to meet with your colleagues in another country. In the early stages, determine which professional meetings at an international conference that it might be effective to submit a co-authored poster or symposium. Apply for student and early career travel awards. Ask your collaborator about opportunities to fund visiting scholarships, and consider international fellowships such as those offered by Fulbright. Dr. Flanagan was awarded a visiting professor fellowship

to Macquarie University, also affiliated with CREMS. Dr. Barrett spent an informal weeklong visit at the Medical University of South Carolina (MUSC) last year and will spend nearly a full year in 2016 at MUSC on a prestigious Fulbright fellowship. In the future, Dr. Flanagan aims to apply for a Fulbright Specialist fellowship or a visiting fellowship through the University of New South Wales (UNSW) to facilitate startup of data collection to take place at UNSW/CREMS. These awards are well within the reach of early career investigators and they are challenging, but extraordinary and highly rewarding experiences.

In summary, we hope that learning some details of our experience and our collaboration model encourages you to explore options that match your professional goals and personal lifestyle. We have dedicated a great deal of work to our collaboration, but it remains entirely worthwhile. We hope that your experiences will be equally rewarding and productive. Good luck!

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APA Trauma Psychology Division: International Student Travel Assistance Stipend to 2015 APA Convention

Elizabeth Carll, PhD, Chair
International Committee

APA Division 56, Trauma Psychology, is providing a travel stipend to assist international students enrolled in a graduate program in psychology who will be presenting a trauma-related poster or presentation at the 2015 APA Convention in Toronto, Canada. The stipend consists of $500 plus the convention registration fee. In addition, a one-year membership in Division 56 will be provided to the recipient of this travel stipend.

Applicants must either be citizens of, live, and study in developing countries or citizens from developing countries while currently attending college in the United States. The stipend is intended as partial support and additional support from other institutions and organizations is also encouraged. Deadline for submission is May 7, 2015.

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

Posttraumatic Growth: What Doesn't Kill You Makes You Grow

By Jack Tsai, Ph.D.

The field of trauma research has focused on the negative outcomes of trauma exposure, but often neglects the potential growth that can occur after traumatic experiences. This article defines posttraumatic growth (PTG), discusses its prevalence, and introduces the idea of PTG in clinical care, with the ultimate goal of encouraging clinicians to consider PTG and promoting its development among clients. Posttraumatic growth (PTG) is defined as positive, meaningful psychological changes that an individual can experience as a result of struggling with traumatic and stressful life events (Zoellner & Maercker, 2006). PTG includes developing an increased appreciation of life, greater personal strength and self-understanding, and renewed appreciation for intimate relationships (Tedeschi, Park, & Calhoun, 1998). Resilience is often confused with PTG, but the two should be treated as distinct concepts. Resilience is about a rapid return to baseline functioning following trauma exposure (Southwick, Bonanno, Master, Panter-Brick, & Yehuda, 2014), whereas PTG is about struggling to deal with trauma and its psychological consequences and experiencing positive change as a result (Tedeschi & McNally, 2011).

Jack Tsai, Ph.D.

PTG is a common phenomenon and many types of trauma survivors have reported PTG, including ex-prisoners of war, assault survivors, war veterans, refugees, and individuals with serious medical conditions and injuries. Using a wide range of methodologies, many studies (Pietrzak et al., 2010; Kleim & Ehlers, 2009) have found that at least half of trauma survivors report some PTG. In fact, growing research has shown that a certain amount of posttraumatic stress is necessary for PTG to develop. For instance, a recent meta-analytic review (Shakespeare-Finch & Lurie-Beck, 2014) reported that there was a significant linear relation between PTSD and PTG, but an even stronger curvilinear relation (Shakespeare-Finch & Lurie-Beck, 2014; Tsai, El-Gabalawy, Sledge, Southwick, & Pietrzak, 2015). An inverted U-shape has been found to best explain the relation between PTSD symptoms and PTG, such that those who report moderate PTSD symptoms endorsed greater PTG than those who report lower or higher levels of PTSD symptoms (Tsai, El-Gabalawy, Sledge, Southwick, & Pietrzak, 2015).

Our group has conducted a study of a nationally representative sample of U.S. military veterans and found that 50% of all veterans and 72% of veterans who screened positive for PTSD (i.e., PCL scores ≥ 44) reported a "moderate" or greater degree of PTG in relation to their worst traumatic event (Tsai et al., 2015). Among veterans with PTSD, those with PTG reported better mental functioning and general health than those without PTG. We also found that greater social connectedness, intrinsic religiosity, and purpose in life were independently associated with greater PTG (Tsai et al., 2015). We have now followed these veterans over two years, and we have found that 59% of veterans maintained a "moderate" or greater level of PTG over time (Tsai, Sippel, Mota, Southwick, & Pietrzak, under review).

Interventions

There have been few interventions developed to specifically promote PTG, as facilitating PTG is a gradual, complex process that involves dialogue between the therapist and client, insight by the client, and patterns of thoughts and actions towards change (Calhoun & Tedeschi, 2014). That change, as described below, may be incremental and non-linear so patience and understanding from both clients and therapists is needed (Hayes, Laurenceau, Feldman, Strauss, & Cardaciotto, 2007).

When modifying existing therapeutic interventions to facilitate the occurrence of PTG, therapists may need to deliberately focus on a specific category for change: in one's sense of self, in relationships with others, and in one's spirituality or religion (Calhoun & Tedeschi, 2000). Journaling and expressive writing about growth from trauma have shown to be helpful in facilitating PTG and should be considered as a way to promote growth (Smyth, Hockemeyer, & Tulloch, 2008; Ullrich & Lutgendorf, 2002). There are also other alternative approaches, like mindfulness and art therapy programs, that may support PTG (Garland, Carlson, Cook, Lansdell, & Speca, 2007; Jim & Jacobsen, 2008) and be offered in psychotherapy. However, exactly how to incorporate PTG into existing evidence-based psychotherapy needs to be investigated.

Besides individual-based approaches, there is great promise for PTG in group-based approaches as well.

Most group-based interventions developed for PTSD (Schnurr et al., 2003) do not focus on PTG. However, the general benefits of group and peer-support are well-known (Yalom & Leszcz, 2005) and may be harnessed to promote PTG. Group-based formats may be an ideal environment for some people to develop PTG, as group members can offer support, mentoring, and understanding (Yalom & Leszcz, 2005). For example, groups for adults with cancer where members process their illness and support each other have been found to increase development of PTG (Jim & Jacobsen, 2008). Given this is a new area, there are many opportunities for clinicians to develop new ways to foster PTG in individual and group-based approaches.

PTG is common among trauma survivors, but is rarely discussed in clinical settings. In my own clinical work, I rarely see PTG being discussed in treatment meetings or in consultations between colleagues. Part of the problem is that there have been few interventions developed specifically for PTG, but that does not mean it cannot still be a point of focus in clinical work. Clinicians working with trauma survivors can encourage perspectives focused on PTG and explore creative ways to foster personal growth. Clearly more research is needed on standardized interventions for PTG to guide clinicians and promote recovery-oriented care beyond the absence of psychopathology.

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Sexting, an Old Problem with a New Name: Challenges for Education and Empowerment

By Ani Kalayjian, Ph.D., and Liya Zhu, M.A.

As cell phone technology has advanced, the practice of sending suggestive and explicit pictures has increased in the past decades. This practice has been defined as "sexting," and includes sending sexually explicit texts or pictures via cell phone or instant messenger, and it can be a serious problem, especially among teenagers.

Ani Kalayjian, Ph.D.

In a 2008 survey (Cosmogirl.com) of 1,280 teenagers and young adults of both sexes sponsored by The National Campaign to Prevent Teen and Unplanned Pregnancy, 20% of teens (13-20) and 33% of young adults (20-26) had sent nude or semi-nude photographs of themselves electronically. Additionally, 39% of teens and 59% of young adults had sent sexually explicit text messages. However, a widely cited study (Mitchell & Wolak, 2011) indicated the previously reported prevalence was exaggerated. The researchers surveyed 1,560 children and caregivers, reporting that only 2.5% of respondents had sent, received, or created sexual pictures distributed via cell phone in the previous year.

Liya Zhu, M.A.

Another study conducted by Strassberg, McKinnon, Sustaita and Rullo (2012) has received wide international media attention for calling into question the findings of Mitchell et al. (2011). Their research surveyed 606 teenagers ages 14-18 and found that nearly 20% of the students said they had sent a sexually explicit image of themselves via cell phone, and nearly twice as many said that they had received a picture. Of those receiving such a picture, over 25% indicated that they had forwarded it to others. In addition, of those who had sent a sexually explicit picture, over a third had done so despite believing that there could be serious legal and other consequences if they got caught. Students who had sent a picture by cell phone were more likely than others to find the activity acceptable. Strassberg et al. (2012) noted: "The newsworthiness of [the University of New Hampshire study] derives from [their] figure [2.5%] being far below (by a factor of 5 or more) the prevalence rates reported in the previous surveys. However, while technically accurate, the 2.5% figure is actually rather misleading" (p. 20). According to these authors, we need to improve our educational efforts to include phone safety assemblies, and awareness days, etc. to raise consciousness about the potential consequences of sexting among young people.

Teen Sexting Law in New York

Since 2009, about 19 states have adopted teen sexting laws and an additional 13 states are considering bills on the issue (Sexting Legislation, 2012). Under New York law, it is a crime to persuade someone younger than 17 to engage in the making of a sexual or nude image, or to distribute or disseminate child pornography featuring a minor. The law also makes it a crime to possess a nude or sexual depiction of someone younger than 16. For example, a teenager who shares a nude photo of a 14-year-old girl with his friends could be convicted of possessing and distributing child pornography.

Like other states, New York has inconsistent child pornography laws: It is not a crime to possess child pornography featuring a 16-year-old, but making or distributing such pornography is illegal (N.Y. Pen. Law 263.00, 263.05, 263.10, 263.11, 263.15, 263.16). It is also a crime in New York to use a computer network to send any obscene material to a child younger than 17 or engage in sexually explicit communication with such a child. For example, a high school senior who sends a freshman a photo of his or her genitals could be convicted under this law. Sharing obscene material with a child is punished more severely if the sender asks the child to engage in sexual activity (N.Y. Pen. Law 235.20, 235.21, 235.22).

Youth Empowerment

The Youth Empowerment Program (YEP), is part of The Association for Trauma Outreach & Prevention (ATOP)

Meaningfulworld, which is a not-for-profit humanitarian organization dedicated to peace, dignity, and compassion through forgiveness and integrative healing. The goals of YEP are to strengthen families, to prevent trauma, to empower youth and to promote health, mindfulness, and positive meaning. YEP was originally developed as a response to the national bullying crisis (Kalayjian, 2012), and it was similarly applied to sexting in order to increase the awareness of its potential consequences, and to promote empowerment through communication and improve self-esteem. In YEP, we utilized ATOP's 7-Step Integrative Healing Model to transform suffering and humiliation into lessons learned and posttraumatic growth (Kalayjian, 2002).

Like bullying or cyber bullying, sexting also has both long-term and short-term negative consequences for victims, which range in severity (Rigby, 2001). These consequences include many psychological issues, such as anxiety, humiliation, embarrassment, depression, psychosomatic symptoms, difficulty sleeping, and suicidal ideation and suicide attempts. In addition, these consequences also involve physical effects, including self-directed violence (i.e. cutting), damaging property, and behavioral issues, such as avoidance of school in general or particular areas of school, which can later lead to issues with academic functioning (Rigby 2001; Leff, 2007).

Each session of YEP consists of a combination of discussions, activities, crafts, role-play, physical release, and occasionally PowerPoint lectures and films. The schedule and topics are tailored to the needs of each individual class, with a focus on increasing awareness of sexting and promoting positive growth and empowerment. The first session of YEP begins with a pre-program assessment that measured empathy and self-esteem. After the assessment, teenagers discussed their definition of sexting and shared their related experiences. The second session is geared toward activities that would be helpful in enhancing empathy, such as role playing, first amongst mentors then having students replicate it amongst themselves, with the guidance of the mentors. Within the third session, group leaders explained the importance of identifying one's feelings. A subsequent session focused on various ways the students would respond if they were involved in sexting situations. In an anti-bullying session, some students mentioned telling an adult, but many students talked about physically beating or punching the bully and running away without thinking of consequences. Positive and negative consequences of these actions were then discussed. In addition, students were encouraged to come up with healthier, non-violent ways of responding. Sexting was expressed as more difficult to cope with than bullying due to the humiliation, especially if the sexual images were of themselves.

The outcomes of using the 7-Step Integrative Healing Model included increase trust; improved relations among the students in each class, mindfulness, meditation, breath work, and encouraging response instead of reaction (Kalayjian, 2002). The model has been incorporated in ATOP Meaningfulworld monthly certificate training programs, as well as in over 45 countries around the globe in response to trauma and conflict and has been modified for teenagers.

ATOP Meaningfulworld has received calls from different schools for this outreach project. The project now has expanded to include after school clubs called Students for Meaningful Solutions (YEP-SMS). At the end of the school year, we will have a summit at the United Nations on 11 June to hear from the youth. With funding support ATOP Meaningfulworld will be able to expand to more schools and communities, as well as expanding the support to teachers, and parents. Monthly supportive groups are recommended for parents as well as teachers to increase the awareness of negative impacts of sexting.

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for student forum

Applying Yoga and Mindfulness to Trauma Recovery

By Lisa Danylchuk, Ed.M., LMFT

In recent years, yoga and mindfulness have become increasingly recognized as treatment interventions that are proving helpful for clients recovering from traumatic experiences. As these strategies increase in popularity, it is important providers continue to learn how to best apply them. This article serves as an introduction and guide for those seeking to further integrate these concepts into trauma theory and practice.

Lisa Danylchuk, Ed.M., LMFT

Yoga and the Window of Tolerance

You will be hard pressed to attend a lecture on trauma these days without someone referencing the nervous system's window of tolerance (Siegel, 1999). Interestingly, the concepts of hyper- and hypo-arousal are also evident in ancient yogic texts that date back to 400-200 BCE (Davis, 2014). For example, the Bhagavad Gita references the *gunas,* or qualities of life and lists them as *tamas*, *rajas*, and *sattva*. *Tamasic* qualities are heavy, lethargic, slow moving and slow thinking; similar to the qualities we see when a client's nervous system is hypoaroused. By contrast, *rajasic* qualities are fiery, athletic, prone to movement and hyperactive, much like that of a hyperaroused nervous system.

As with the Window of Tolerance model (Siegel, 1999), the yogic approach is to balance these energies and cultivate what yogis call *sattva,* a state that trauma therapists similarly describe as being "within the window of tolerance." When we are within the window, we exhibit the *sattvic* qualities of being calm, alert, present, available for connection and appropriately responsive to our surroundings. For centuries, yogis have been practicing breath work, postures, and directing attention in order to cultivate this even, balanced state of being (Davis, 2014). Now trauma therapists can use these time-tested strategies and apply them to our current knowledge of the nervous system and its role in trauma recovery.

The Role of the Body

Along with the developing understanding of the nervous system's role in trauma and recovery, researchers and trauma therapists are developing a deeper understanding of the power of incorporating physical movement into trauma recovery. In a recent interview with the National Institute for the Clinical Application of Behavioral Medicine, Peter Levine, a leader in the field of somatic psychotherapy and trauma recovery, told host Dr. Ruth Buczynski that he expects the body will play an increasingly powerful role in the future of trauma treatment (Buczynski & Levine, 2014). Bessel van der Kolk, founder and director of the Trauma Center in Brookline, Mass., highlights the importance of movement and of yoga in trauma recovery in his recent book *The Body Keeps the Score* (van der Kolk, 2014). Rather than the neurologically "top-down" approach of using the mind to heal emotions and sensations, yoga employs a "bottom-up" approach, allowing for the movement and position of the body to impact mental and emotional states (van der Kolk, 2014). Yoga postures give practitioners a way to access and challenge existing physiological, psychological and neurological states.

Pat Ogden, a leader in the field of somatic therapy, and Amy Cuddy, professor at the Harvard Business School, are also exploring the impact of body postures on internal states, beliefs, and even hormones. For example, Carney, Cuddy, and Yap (2010) discovered that changing body positions can have an impact on hormone levels in just two minutes. Much of our communication is nonverbal, and the body, even when we many not want it to, can speak for us. Yoga helps us to work with these physical, often less conscious aspects of ourselves and allows us to use the body to influence our biology and hence our experience of the world.

Your Brain on Yoga

While many areas of the brain come into play with yoga and mindfulness practices, a recent area of interest is the prefrontal cortex, specifically the medial prefrontal cortex because of its ability to associate experience and memory – that is, to make sense of and process the vast range of experiences of our lives (Shin, Rauch, & Pitman, 2006). Researchers have found a decrease in activity in this part of the brain in those suffering from posttraumatic stress disorder (Shin et al., 2006). Conversely, mindfulness meditation has been shown to increase thickness in the prefrontal cortex (Lazar, 2005). The simple yogic practice of being mindful of sensations and thoughts as they occur, disengaging from patterns of thought and focusing instead on breathing and sensation can help engage the

prefrontal cortex and transition our system into a more calm and present state – or *sattvic* – state.

In addition to resting the mind on the breath, the breath itself can help bring healing. Different schools of yoga emphasize a variety of breathing techniques, and many recognize the benefit of lengthening the breath (Iyengar, 1993). For instance, according to Stephen Porges' polyvagal theory (Porges, 2011), the extended exhale increases the influence of the myelinated vagus nerve, which is associated with social engagement (Buczynski, Porges, 2012). So activities like pranayama (yogic breath work), chanting and singing help to tone the nervous system and build its ability to calm itself and help us connect with others.

The Heart of Yoga

Whether or not we can do mental or physical gymnastics, the practice of simply moving, attending the mind and breathing impacts the heart, specifically heart rate variability (HRV). While yogis have long proclaimed that yoga positively impacts HRV, recent research has confirmed this assertion (van der Kolk et al., 2014). Specifically, researchers van der Kolk and his research team found that increasing HRV not only correlates with increased physiological health but also a reduction in post-traumatic symptoms. While not everyone can run marathons (another activity associated with improved HRV), yoga is an adaptable resource and even those with limited physical capacity can access this practice (van der Kolk et al., 2014).

As we know in psychotherapy, relationships themselves are healing, and helping trauma survivors reconnect with others is a significant part of the healing process. At the heart of yoga, in addition to, and perhaps beyond, all the potential benefits outlined above, is the teacher-student relationship. Within this relationship is the opportunity to be seen and held in a safe space while being guided through physical and emotional processes that can seem daunting. Indeed, yoga can be a trigger as well as a resource. Many teachers consider yoga a moving mindfulness meditation and research indicates that one risk factor in meditative practices is that they can uncover repressed memories and emotions (Miller, 1993). It is important that we as clinicians encourage experiences for clients that are safe, moderate, and allow for organic well-attuned relationships between teacher and student.

Part of the role of the trauma therapist is to prepare clients for yoga and process the material that arises during practice. Many clients are not aware that yoga can bring up emotionally challenging material; therefore, identifying this is helpful in preparing clients to practice. In addition, developing a resourcing technique, such as feeling the feet in contact with the floor or imagining a peaceful place, can help clients tolerate the intense emotion, should it arise. If the clinician is knowledgeable about yoga, it is a good idea to practice these techniques in therapy prior to recommending it clients, so that they are prepared and have tools when the enter a class setting. Another way to support clients is to help them develop a pace that feels approachable; rather than jumping in to the biggest challenges of yoga, guide clients to pendulate from the safe to the unexplored and back to the safe. This will help them keep their yoga practice, and processing, more sustainable, and brings the powerful element of choice into the client's experience (Emerson, 2015).

These are just some of the aspects of healing available through the practice of yoga, the power of which as a preventative practice is hard to measure. However, knowing these benefits and the struggles trauma survivors face, I would recommend an adaptive, supported yoga practice to trauma survivors seeking an improved state of physical and mental health. Yogis and trauma therapists alike are on a quest to balance the nervous system, practice bottom-up processing, increase matter in the prefrontal cortex, improve HRV and foster safe, contained relationships and environments for healing. Working together across theses disciplines as we continue to explore the mechanisms of healing available will allow us to offer the most comprehensive support to those facing adverse life experiences.

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Conceptualizing Trauma: In Pursuit of Culturally Relevant Research

By Jennifer M. Gómez, M.S.

Betrayal in Trauma Research

As a clinical psychology doctoral student who researches interpersonal trauma and works clinically with individuals who have experienced such trauma, betrayal is a frequent topic of discussion. In Dr. Jennifer J. Freyd's Dynamics Laboratory at the University of Oregon, my colleagues and I study several kinds of betrayal in trauma—interpersonal (e.g., Freyd, 1996), institutional (Freyd & Birrell, 2013; Gómez, 2013a; Gómez & Freyd, 2014a; Smith & Freyd, 2013; Smith & Freyd, 2014) and judicial (Smith, Gómez, & Freyd, 2014). In betrayal trauma theory [BTT], Freyd (1997) proposes that abuse perpetrated by someone close is indicative of a high betrayal that uniquely contributes to negative outcomes. As an undergraduate, BTT provided validation for what I understood of trauma—the social context of abuse matters. Consequently, I felt hopeful that I could create a space for meaningful trauma research in my own career. In fact, collaborating with Freyd already has allowed me to contribute such work (e.g., Gómez, Becker-Blease, & Freyd, 2015; Gómez, Kaehler, & Freyd, 2014).

Jennifer M. Gómez, M.S.

However, outside of this collaboration, I sometimes feel isolated from my peers as the only Black student in my program. Cultural differences, which at times have engendered imposter feelings (Gómez, 2013b), increased an internal tension between my professional and personal identities; I was trying to fit myself within the field while desperately needing to retain *me*. I experienced betrayal in trauma psychology not from my work with Freyd, but from the absence of ethnic minorities like myself in the majority of samples used in trauma research; this created an underlying disconnection to the field generally, which inspired me to seek out diverse samples in the literature.

Diverse Populations, Sociocultural Contexts, & Cultural Values in Trauma Research

In gathering readings for my preliminary examinations, entitled *Interpersonal Trauma in Context: Theory, Evidence, and Clinical Implications*, I found it difficult to find contextualized research—that is, work that incorporates societal trauma (e.g., discrimination; Bryant-Davis, 2005b) and cultural values (e.g., Strong Black Woman Ideology; Wright, Pérez, & Johnson, 2010)—on cultural minorities, such as people of color, non-heterosexuals, and foreign nationals. While I drew from the brilliant work by contemporary authors (e.g., Bryant-Davis, Chung, Tillman, & Belcourt, 2009), I noticed the relative dearth of knowledge of contextualized trauma research on persons from non-dominant groups. I remain unsure if this scarcity is a result of actual devaluing of these groups and constructs or of privileging views of trauma that promote the values of the dominant American culture (e.g., individualism). Perhaps the cause is a mixture of things along with other factors, such as limited diversity of ethnicities, cultures, and backgrounds of researchers. Whatever the reasons, I am committed to spending a career conducting research that aligns with my own values and norms.

Senior researchers are already producing contextualized trauma research, including Bryant-Davis' (2005b) book *Thriving in the Wake of Trauma: A Multicultural Guide*, which uniquely expanded upon Herman's (1997) seminal book, *Trauma & Recovery*. Upon reading this book, I was given new hope for what I believe can become normative in trauma research: incorporating multiple sociocultural contexts, cultural values, identities, social locations, and cultural categories. These and other constructs affect the experience and meaning-making of trauma, negative

outcomes, and positive coping strategies (Brown, 2008; Bryant-Davis, 2005b). Innovative work like this has not only given me hope that my perspective has a place in the field, but also has motivated me to propose a new culturally relevant theory in trauma psychology.

Cultural Betrayal Trauma Theory

Expanding on the theoretical foundation of BTT (e.g., Freyd, 1997), I am developing cultural betrayal trauma theory (CBTT; Gómez, 2012, 2013a, 2014, 2015, under review; Gómez & Freyd, 2014b; Gómez, Smith, & Freyd, 2014). According to CBTT, societal trauma, (intra)cultural trust, and cultural betrayal may be contributing factors to trauma outcomes for members of cultural minorities. Resulting from societal trauma, cultural minorities may develop (intra)cultural trust, which is connection—dependency, attachment, loyalty, love, and/or responsibility—for and with other known and unknown in-group members. (Intra)cultural trust is similar to racial loyalty, a construct already in the literature (e.g., Tillman, Bryant-Davis, Smith, & Marks, 2010), and can buffer against mistreatment by individuals and institutions of the dominant culture. Cultural values, such as those that emphasize the importance of community (e.g., Africentric communal values) may additionally affect both (intra)cultural trust and experience of cultural betrayal.

I define cultural betrayal as the violation of (intra) cultural trust in the form of trauma, abuse, violation, or other harmful interactions perpetrated by presumed in-group members of cultural minorities. Jointly examining interpersonal betrayal—perpetrated by trusted or depended upon others (Freyd, 1996)—and cultural betrayal can aid in understanding trauma outcomes. For instance, in the first study testing CBTT, cultural betrayal trauma by someone close predicted the development of PTSD symptoms (Gómez & Freyd, 2014b).

Societal trauma, (intra)cultural trust, interpersonal betrayal, cultural betrayal, and the abuse itself contribute to cultural betrayal trauma in this theory, so I hypothesize that the outcomes in CBTT are likely to be similarly diverse—ranging from typically-studied sequelae, such as PTSD, to cultural outcomes, such as internalized prejudice (*Figure 1*). A hypothetical example can illuminate the varying harms of cultural betrayal trauma:

> A Black American woman attends a party hosted by a Black American fraternity that has been a source of emotional support for her at the predominantly White university she attends. At this party, she is raped by a presumed Black American male party-goer. Following the cultural betrayal trauma, this woman experiences symptoms of PTSD—hypervigilance around Black American men of the same build and complexion as the perpetrator. This heightened fear also contributes to internalized racism, as she thinks, "Maybe Black people really are violent and criminal."

Though hyperarousal around similar stimuli may be expected following rape, according to CBTT, societal trauma of discrimination and cultural betrayal uniquely contribute to the cultural outcome of internalized prejudice. As the aforementioned example illustrates, CBTT provides a clear avenue of assessing understudied outcomes of interpersonal trauma for cultural minorities, who themselves are largely excluded from the trauma literature. Additionally, mediating psychological processes, such as connection with cultural minority identity, may ameliorate both negative and positive post-trauma outcomes and can be explored through the lens of CBTT as well.

Next Steps

The field of trauma research has demonstrated its ability to support dominant trends, such as the fear paradigm (DePrince & Freyd, 2002), while allowing for paradigm shifts. The 20 years of research supporting BTT (e.g. DePrince et al., 2012; Gómez et al., 2014) is one such paradigm shift. I believe the field is ready to similarly support contextualized trauma research. For instance, at the American Psychological Association's 2013 Annual Convention, Bryant-Davis won the Distinguished Contributions to Psychology in the Public Interest (early career) Award for her work in socially relevant trauma research (Bryant-Davis, 2013). At that same convention, I was honored with the Anne Anastasi General Psychology Graduate Student Award from Division 1 (Society for General Psychology) for my work in trauma, including the introduction of CBTT (e.g., Gómez, 2015). Therefore, I am relentless in my optimism that the field can further support research that utilizes non-dominant frameworks. As outlets for professional communication, peer-reviewed journals are one such avenue of support. At best, the peer-review process facilitates producing high quality theoretical and empirical work that advances the field; at worst, this process can be oppressive, reinforcing dominant views while silencing cultural minority perspectives (Gómez, 2014). By peer-reviewed journals prioritizing contextualized trauma research on diverse populations, trauma psychology can remain relevant in an increasingly pluralistic society.

Through privileging work that identifies and examines trauma and its outcomes in diverse populations and/or under new or understudied frameworks, including but not limited to CBTT (e.g., Gómez, 2015), we can accomplish our goal of conducting contextualized trauma research (Gómez, 2014) that expands our base understanding of trauma and its effects across diverse populations. This work can provide evidence for needed culturally sensitive strategies in clinical interventions (e.g., Gómez, under review) that has the potential of ameliorating the negative outcomes associated with trauma, while bolstering positive coping strategies, such as social advocacy (Bryant-Davis, 2005a).

In summary, contextualized trauma research provides

insight into how trauma differentially affects individuals as a function of aspects of the sociocultural context, identity of and relationship with perpetrator(s), cultural values, and many other factors (e.g., Bryant-Davis, 2005b; Freyd, 1996; Gómez, 2015). Therefore, just as BTT (e.g., Freyd, 1996) has expanded what we know of trauma sequelae to include varied trauma outcomes (DePrince et al., 2012), the field can similarly benefit from generating contextualized trauma research as it is precisely this kind of work that can advance the field.

Concluding Thoughts

Upon entering graduate school three years ago, I was determined to acclimate to an environment vastly different from my own. Upon finding a home in Freyd's lab, I now view full assimilation into academia as not only too costly (Gómez, 2014), but also

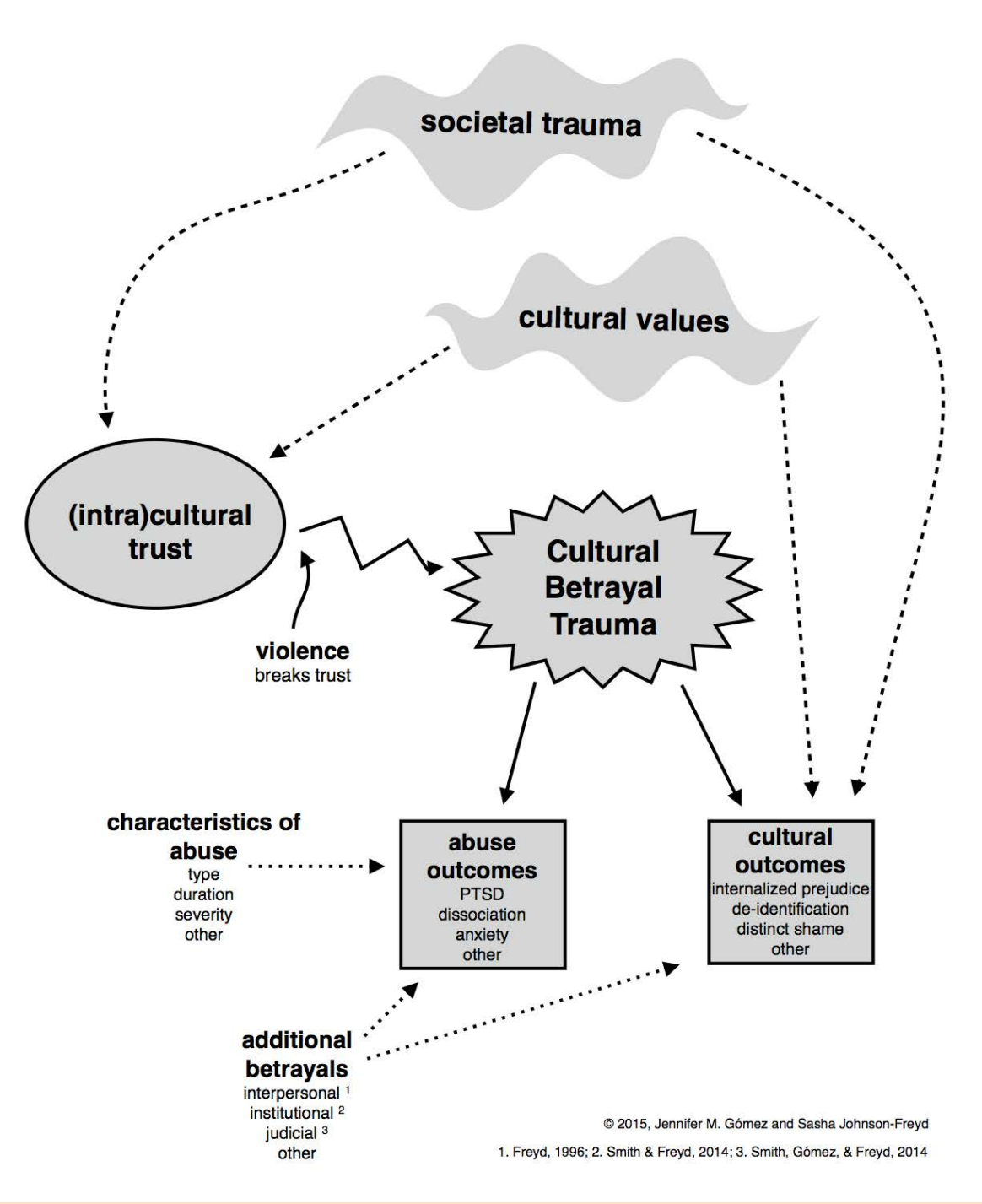

Figure 1. In addition to the impact of societal trauma, cultural values, (intra)cultural trust, characteristics of abuse, and additional betrayals, cultural betrayal trauma predicts abuse and cultural outcomes.

deeply detrimental to the field as a whole: singular perspectives lead to limited knowledge of psychological and behavioral phenomena, such as trauma sequelae. Pioneers in the field, such as Herman, Freyd, and Bryant-Davis, paved the way for students like me to integrate our professional and personal identities and insight into developing innovative frameworks that can engender research in understudied populations and constructs (e.g., CBTT; Gómez, 2015). However, another crucial piece of contextualizing trauma research is the acceptance and privileging of such work by both individuals (e.g., researchers) and systems (e.g., journals) in the field.

This acceptance will foment further research and deeper examination of these constructs, which can impact clinical interventions. For instance, from the inception of my clinical work with persons who have experienced trauma, I have incorporated BTT into my case conceptualizations, and have also shared this empirically supported information with my clients. It has been rewarding also to incorporate CBTT into my clinical work: for example, understanding how (intra)cultural trust affects some ethnic minority clients' decisions not to report violence to the police. It is exciting to think how empirical investigation can provide further insight into trauma sequelae that informs culturally congruent clinical interventions.

As the field continues to evolve, it is my hope that trauma research will grow closer to mirroring the reality of lived experiences for diverse persons who have primary and/or secondary experiences with trauma. In our future, I envision graduate students from diverse backgrounds, not unlike myself, entering academia. Instead of feeling betrayal from exclusionary thought within the field at large, they will feel at home—able to create niches for themselves in a discipline that is ready for their contributions in understanding the experience of trauma.

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Call for Division 56 Award Nominations 2015

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

In the nominating letter, it is of utmost importance to explain the candidate's suitability for the particular award, their accomplishments, and specifically, their contributions made to the field of trauma psychology. Please also include a copy of the nominee's curriculum vitae. Self-nominations are accepted. **Deadline: April 20, 2015.**

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

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

Award for Outstanding Contributions to the Science of Trauma Psychology
This award recognizes distinguished contributions to scientific research. It may be given in recognition of a particular discovery or for a sustained body of research and scholarship.

Award for Outstanding Service to the Field of Trauma Psychology
This award recognizes sustained contributions of leadership in the field of trauma psychology.

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

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

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

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

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

FELLOWS

New Fellow: Denise M. Sloan, Ph.D

Denise M. Sloan, Ph.D., is a professor of psychiatry at Boston University School of Medicine and is associate director, Behavioral Science Division, at the VA National Center for PTSD. She graduated with honors in psychology from Stony Brook University and completed her Ph.D. in clinical psychology from Case Western Reserve University. Her research expertise is in psychosocial treatment for PTSD and emotion in psychopathology. She is particularly interested in identifying ways to make trauma treatment more efficient and effective. She currently serves as principle investigator for two randomized controlled trials investigating two types of PTSD treatments. The first is studying the efficacy of group cognitive behavioral treatment for PTSD relative to group present-centered treatment. The second study is examining whether a brief, exposure-based treatment for PTSD is equally effective as cognitive processing therapy. She has received funding from several organizations, including the National Institute for Mental Health, Department of Veterans Affairs, and the Department of Defense.

Denise M. Sloan, Ph.D.

Dr. Sloan is an associate editor of Behavior Therapy and serves on several editorial boards, including Behaviour Research and Therapy, Journal of Abnormal Psychology, Journal of Clinical Psychology, and Psychosomatic Medicine. She has been an active member in Division 56, serving as co-chair of convention programming and chair of the publications committee. In her free time, Dr. Sloan enjoys spending time with her husband and son, exploring new restaurants in the Boston area, and attending SoulCycle classes.

FELLOWS

Call for Fellowship Applications

We invite and encourage individuals who have "shown evidence of unusual and outstanding contributions or performance in the field of (trauma) psychology" (APA's hallmark criterion) to apply for Fellowship status within Division 56. You must be an APA member for one year, and a current member of Division 56.

APA members who are not yet Fellows of any APA division must meet APA Fellow criteria, apply for Fellow Status according to APA procedures, and complete the APA forms, all described at http://www.apa.org/membership/Fellows/index.aspx. You will find everything you need to know about applying at the above APA web address.

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

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

1. Being a pioneer in the recognition and application of trauma psychology

2. Publishing important publications to the field of trauma psychology

3. Producing consistently outstanding instructional or trai ing programs that educate the next generation of trauma psychologists or developing important innovations in teaching or education in the field.

4. Demonstrating consistently outstanding clinical work with the traumatized as recognized by international or national groups through citations, awards, and other methods of recognition.

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

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

In order to meet APA's February deadline, Division 56 requires that all new Fellow application materials (including recommendations) be submitted through the APA web site by **November 1**. This timeframe will allow our Fellow committee to review all materials, make a

recommendation, and forward completed application materials to APA in time to meet their deadline.

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

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

MULTIMEDIA REVIEWS

A Trauma-Informed Review of the Classic Children's Film, *Hook*

By Kalila Beehler, M.S.

Kennedy, K., Marshall, F., & Molen G.R. (Producers), & Spielberg, S. (Director). (1991). *Hook* (Motion picture). United States: Amblin Entertainment.

Hook is a film that has a great deal to say about human psychological trauma when viewed carefully and thoughtfully. The film comes from Steven Spielberg and it portrays a twist on the classic tale of Peter Pan and Neverland. Throughout the film, one-liners from an adult Peter Pan, Peter Banning (Robin Williams), and the emotionally and verbally abusive actions of Captain Hook (Dustin Hoffman) set the scene for the experience of traumatic events in the lives of Jack and Maggie, Peter's children. Traumatic events are portrayed as normal and insignificant to the storyline, but the trauma-informed viewer may begin to wonder how these children develop later in life after experiencing much family strife and other traumas. We contemplate the impact of multiple adverse childhood experiences and we may wonder about these children's possibility of developing developmental trauma disorder (Van der kolk, 2005). We know that multiple adverse childhood experiences have a strong relationship to suicide, chronic illness, addictions, mental health problems, and early death (Felitti et al., 1998) and that complex trauma can cause "significant difficulties in emotional, behavioral...and cognitive dysregulation" (Kliethermes, Schacht & Drewery, 2014, p. 339). Given what we know, it is certain that the multiple traumas experienced by Jack and Maggie should be more impactful than the film portrays.

Kalila Beehler, M.S.

Peter: "Jack, my word is my bond"
Jack: "Yeah, junk bond."
Peter: "What in the hell's the matter with you? When will you stop acting like a child?"
Jack: (chuckles) "I am a child."
Peter: "Grow up." (Kennedy, Marshall & Molen, 1991)

As *Hook* begins, it becomes evident from a therapeutic view that Peter is an absent father who is over-engaged in his work: he sends his subordinate colleagues from his office to record Jack's baseball game so that he does not need to be present; he takes work phone calls during Maggie's theatre production; and he is reluctant to engage with their creative souls when Jack and Maggie are being put to bed. Jack's drawing of a plane on fire with everyone except for Peter having a parachute evokes an intense discussion between Jack and his dad and this permits us to gaze into the effects of Peter's actions on Jack early in the film. As a case conceptualization, we begin to wonder if Jack feels neglected by and angry with his father.

The abduction to Neverland by Captain Hook and his crew is a significant traumatic event for Jack and Maggie and they are further impacted when Captain Hook's crew hoists them perilously high in the air in a fishing net. This event provides a concrete reminder of their father's failure to provide and protect as he cannot reach far enough to save them. Grooming behavior is used by Captain Hook to convince Jack that he loves Captain Hook more than his biological father, which poses some additional psychic confusion for Jack. Meanwhile, his sister Maggie remains resilient and focuses on not letting Neverland take her memory and remembering her mother and their home.

Peter: "...What, a five billion dollar deal falling apart because of this? Why doesn't somebody just shoot me in the head?"
Jack: [making a gun gesture with his hands] "Bang, Bang!"
Peter: "Will everybody just shut up!"
Jack: [backing away in fright] "I'm sorry."
Peter: "And leave me alone for one moment! Moira, get 'em outta here, will you? I'm on the phone call of my life!"
Moira: [exits Maggie and Jack] "Come on, Jack, come on. Out, out, out." (Kennedy, Marshall & Molen, 1991)

We know that a child or adolescent's efforts to cope can moderate the impact of stress on their physical, social, mental, and emotional well-being (Compas, 1987; Aldao, Nolen-Hoeksema & Schweizer, 2010). It is therefore interesting to see the positive resolution of the traumas experienced as presented by the film despite minimal focus on coping. Maggie, Peter's daughter, does exhibit a strong desire not to forget her mother and their home. Although she has an idealized view of their home life and the world, she is able to persevere and not succumb to Captain Hook's efforts to corrupt her view of her father and memories of childhood outside of Neverland. Keeping true to her pre-trauma life seemed to help Maggie mitigate the impacts of the terrors she experienced.

When this film was produced and released to the public in 1991, the old adage that an absent father meant a child—especially a son—would have poorer cognitive performance (Shinn, 1978), inadequate sex role development (Drake & McDougall, 1977), and poor moral development were fresh on the minds of the general public and therapists at the time (Hoffman, 1971). It is no wonder that the depiction of Peter as an absent father gave indications that Jack was distraught and was impacted in daily living, such as doing poorly at his baseball game. Although aspects of these old ideas have been challenged, there is a general consensus that secure attachment provides the healthiest developmental trajectory for children and adolescents (Ainsworth, 1991; Thompson, 2008).

Peter's absenteeism is driven by his work life, which is highly stressful. To cope with all of this stress, particularly while in London, Peter is depicted as drinking copious amounts of alcohol after his children have gone missing. It is only after this that he is able to see Tinkerbell and embark on his adventure to Neverland. Although no other evidence is supplied, the large quantity of alcohol did not seem difficult for him to handle and one implication is that he may drink heavily on a regular basis. It is known that an alcoholic parent may increase the likelihood of experiencing disrupted emotional, social, and academic functioning in children (Cavell et al., 1993). Additionally, as we know that attachment is an important factor in successful childhood development, it is important to note that alcoholism can significantly impact attachment patterns (Cavell et al., 1993). When we combine Peter's potential alcoholism, his absenteeism, evidence of a negative impact on Jack, and knowledge that Jack seems to have insufficient coping mechanisms to deal with the stress caused by his father, we have a production of a traumatic childhood impacting Jack's development.

> Peter Pan: "Jack, Maggie, all you have to do is think one happy thought, and you'll fly like me."
> Maggie: "Mommy."
> Jack: "My dad, Peter Pan." (Kennedy, Marshall & Molen, 1991)

Hook depicts Peter's children as being able to forget all of the past negative memories of their father. Evidence of this includes the fact that Jack's most happy thought, which allows him to be able to fly, is that his dad (whom he is now proud to call dad) is the real Peter Pan. It is not surprising that a discovery that one's parent is a fictitious character would cause any child, particularly at Jack's developmental age or younger, to be in awe of that parent. Although the movie is based in somewhat realistic events and representations of reality, the underlying message could be invalidating to trauma survivors. For instance, individuals may come away from viewing the film having been exposed to messages like, "in the end I will be fine without therapy" and "forgetting about past hurts is a healthy coping strategy." We understand that this sort of avoidance and repression of hurts may not actually lead to healing as the film depicts. Instead, it would be helpful if the film encouraged a processing of one's traumatic events as is used often, for example, in trauma-focused cognitive behavioral therapy (TF-CBT) (Cohen & Mannarino, 2008; Little & Akin-Little, 2009). As clinicians, we could only hope that Jack and Maggie might explore their own experiences to save themselves and others from harm. In this manner, the film could have introduced enlightened witnesses who would have become "aware of the dynamics of child abuse, who [could] help them address their feelings seriously, understand them and integrate them as part of their own story" (Kent, 2004, p. 341).

It is unfortunate that we are left at the cusp of the positive turnaround and never see whether Peter returns to his old and detrimental habits. It is left to speculation, which may lead the viewer to ambiguously assume that everything will be easy from that point on, that Peter will have changed in all aspects of life, and that he will no longer have to deal with stressful situations by drinking alcohol. However, this fairytale ending, or a lack of a story after the resolution, seems inauthentic and could be detrimental to those viewing this film who have experienced trauma and continue to struggle.

As professionals who are working with traumatized people, we need to keep in mind that clients who are bombarded by happily-ever-after stories in their lives and who are living in a world where immediacy is expected and desired may be ill-equipped to cope with the reality that their world is not going to be "fixed" or "normal" once the traumatic situation is over. There needs to be an awareness that recovery from traumatic events is not immediate, and may never be fully resolved (Kliethermes, 2014). Our clients may have different expectations, and through psycho-education, clients can more fully understand and accept the challenges that recovery from trauma can present. *Hook* missed an opportunity to present realistic experiences of trauma and of recovery, and presents life as single adventures and events that are static. If only *Hook* had provided the opportunity to help enlighten our clients to realizing

that their time on Earth is all an adventure, and they are empowered with some control over their future, we might have a film that shows us all that the good, the bad, and the in-between are all parts of a fully lived life. *Hook*, and the many stories like it, presents an unrealistic vision of what it looks like to heal from trauma, and while making for wonderful movies and fantasies, the implicit messages in these stories create unrealistic expectations about recovery for many people.

> Wendy: "It looks like your adventures are over"
> Peter: "Oh no, to live is an awfully big adventure"
> (Kennedy, Marshall & Molen, 1991)

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Kalila Beehler *is a pre-kindergarten therapist at the Center for Autism in Philadelphia. She earned an MS in Clinical and Counseling Psychology from Chestnut Hill College and a BA in Psychology from Bucknell University. Kalila has a passion for working with children, and is in the process of applying to doctoral programs with the ultimate goal of working with lesbian, gay, bisexual, and transgender youth and families.*

BOOK REVIEW

Review of the *Handbook of PTSD*

Friedman, M. J., Keane, T. M., & Resick, P. A. (2014). *Handbook of PTSD (2nd edition)*. New York: Guilford Press. (718 pages). ISBN-13: 978-1462516179 ISBN-10: 1462516173 ($85.00 hardcover).

By Michelle D. Sherman, Ph.D., and Jessica Larsen, Ph.D.

The second edition of the *Handbook of PTSD* by Matthew J. Friedman, MD, PhD, Terence M. Keane, PhD, and Patricia A. Resick, PhD, is a 718-page edited volume that will undoubtedly be a classic in the field of trauma and PTSD. Comprehensive in scope, written and edited by experts in the field from around the world, and accessible for a wide range of readers, this second edition makes an outstanding contribution to the literature.

The editors are three of the most distinguished leaders in the field of PTSD, lending significant credibility to the volume. Dr. Friedman is the Executive Director of the National Center for PTSD, White River Junction VA Medical Center; he also chaired the American Psychiatric Association's DSM-5 Work Group that developed diagnostic criteria for PTSD and related disorders. Dr. Keane directs the Behavioral Sciences Division of the National Center for PTSD, and has held numerous leadership roles in trauma-related organizations. Dr. Resick is a professor of psychiatry and psychology at Boston University, and directed the Women's Health Sciences Division of the National Center for PTSD from 2003 to 2013. All three are highly respected researchers and leaders in the study and treatment of PTSD, and they have compiled an impressive array of contributors for the chapters in this volume.

The volume has 36 total chapters and it is organized in four parts. The first section, the Historical Overview, includes four chapters addressing the history of PTSD, including transitions to the DSM-5. The second section, Scientific Foundations and Theoretical Perspectives, encompasses a broad array of topics. The fifteen chapters herein address epidemiology, advances in trauma research, theories of PTSD, the dissociation

subtype of PTSD, genetics, gender issues, and trauma in older adults. Third, the Clinical Practice: Evidence-Based State of the Art section includes 11 chapters that address assessment and treatment of PTSD in both children and adults, trauma and physical health, culture and PTSD, and forensic considerations. The final section, titled Emerging Territory, involves six chapters that address Internet-based interventions, tele-mental health, resilience, public health interventions, and the implementation of best practices for PTSD. The last chapter is written by the editors; Key Questions and an Agenda for Future Research includes 16 important questions for the field of trauma, each of which can stimulate research, program development, and advances in clinical care. Chapters throughout the text are concise, focused, and easy to comprehend, making the information accessible to a wide range of readers. Many of the chapters follow a helpful structure, beginning with methodological considerations, followed by a literature review, and concluding with challenges for the future involving directions for research and practice.

Michelle D. Sherman, Ph.D.

This second edition improves upon the first edition (released in 2007) in numerous ways. First, this edition incorporates information about the new diagnostic criteria in the DSM-5 as well as research that has emerged in the past seven years. Secondly, chapters have been added to reflect newer areas of research and practice, including couples and family therapies, group treatments, and the dissociative subtype of PTSD. Third, the editors have included chapters by international authors, broadening the scope of the text to a more global outlook. Finally, the fourth section of the book includes chapters that are on the cutting edge of PTSD science, including Internet-based interventions and tele-mental health. All of these revisions significantly strengthen the second edition, making the new volume timely and useful for clinicians, researchers, and policy makers alike.

Jessica Larsen, Ph.D.

Although space constraints likely prevent the editors from addressing issues beyond the wide scope of matters addressed, future editions of this book may wish to include information about the effects of PTSD and trauma on family members. Although there is a chapter on empirically supported couples and family therapies for PTSD, little information is provided about the adverse effects of trauma/PTSD on intimate partners, children, and other family members. Due to the important role of social support in coping effectively with trauma, attention to the impact on family members and the implications for treatment may be useful in a future edition. In addition, a line of literature that has been omitted in this text is the impact of treating PTSD on providers. Future editions of this volume also should consider addressing research findings on the prevalence of provider burnout in trauma treatment, as well as evidence-based approaches for preventing provider stress and burnout. In particular, a chapter for administrators and supervisors in agencies providing trauma treatment that describes institutional supports for providers would be a strong addition.

In the book's preface, the authors describe three goals for their volume, hoping the book will be a useful textbook for graduate courses, support researchers in developing and implementing studies to advance the field, and empower clinicians both green and seasoned to implement the best evidence-based treatments. We are confident that this book will be an excellent resource for all three of these audiences and will shape the landscape of the study and treatment of PTSD in the years ahead. *The Handbook of PTSD (2*nd edition) is a comprehensive, outstanding volume that will be a "must-have" on the bookshelves of those interested in the study and treatment of PTSD.

Michelle D. Sherman, Ph.D. *is a clinical psychologist and research scientist at the University of Minnesota. In her personal life, she also writes books for teens whose parents have mental illness or trauma. Jessica Larsen, Ph.D. is a postdoctoral fellow at the Oklahoma City VA Medical Center and University of Oklahoma Health Sciences Center.*

Jessica Larsen, Ph.D.*, is a postdoctoral fellow at the University of Oklahoma where she specializes in working with clients diagnosed with PTSD. Her research focuses primarily on systems based interventions for individuals with PTSD. She is trained and experienced in evidence based treatments for trauma, including Cognitive Processing Therapy for adults and Trauma Focused Cognitive Behavioral Therapy for children and teens.*

Review of *Spiritually Oriented Psychotherapy for Trauma*

Walker, D. F., Courtois, C. A., & Aten, J. D. (2015). *Spiritually Oriented Psychotherapy for Trauma.* (292 pages) Washington, DC: APA Publishers. ISBN-13: 978-1-4338-1816-5 ISBN-10: 1433818167 (59.95 hardcover).

By Ani Kalayjian, Ph.D.

Spiritually Oriented Psychotherapy for Trauma, a new book edited by Donald F. Walker, Christine A. Courtois, and Jamie D. Aten, attempts to address many challenging issues in highlighting integration of spirituality in psychotherapy. The title may be a little misleading because it could be interpreted to mean that there are new psychotherapies that are spiritually oriented, but the actual focus is on how to integrate spirituality into the traditional psychotherapies working with traumatized individuals. In fact, the authors discuss the impact of trauma on spirituality and faith practice, and they provide ways for practitioners to assist in the integration and the healing process.

Ani Kalayjian, Ph.D.

In 292 pages, the editors acknowledge and are mindful of the challenging task at hand. Each of the 12 chapters is written by multiple authors; there are approximately 37 authors who are experts in this growing field. The authors explore the process of how a therapist might handle the spiritual concepts that emerge in therapy sessions; how spirituality is impacted by trauma, how to assess religious and spiritual impact of trauma, how to address intimate partner violence within a religious context, and how to assess faith and honor with military personnel and their families. They present research findings, and include many thought provoking vignettes, which illustrate the difficulties that emerged in therapy sessions as clients explored their spiritual issues.

The editors elicit how spirituality, religion, and psychology used to be separate. Over the past 20 years, however, they report that psychotherapists have recognized the importance of integrating and being mindful of these faith based concepts within each therapy, especially with traumatized clients. Although the research shows that psychologists are seeing the importance of spirituality in healing, the editors share research findings indicating that in fact psychotherapists rarely engage in spiritual practice or incorporate religious worship. Over 90% of the U.S. general public reported a belief in a personal god whereas only 24% of the psychologists sampled endorsed this belief (Walker et al., 2004). In fact, when trying to integrate spirituality into therapy with a client, this author had been reprimanded by her supervisor less than 20 years ago; even today, there are still few psychology curriculums integrating spirituality.

The editors recognize the challenges many clients face in articulating spiritual impact of their trauma, including the discomfort that could be experienced by therapists themselves. They advise therapists on issues that could arise within a session while providing guidance to their clients. They caution that therapists must consider their own spiritual belief systems and biases to feel comfortable with issues in which they provide counseling. They relate the importance of a therapist's disclosure about the nature of his or her own spirituality and its importance in the therapeutic process. The editors share "take-home points" such as using three broad choices for inclusion in clinical practice: 1. Use secular psychotherapy model for spiritual goals, without explicitly incorporating spiritual content; 2. Use spiritual models for psychotherapy that are devoid of secular content entirely; or 3. Use spiritual interventions within secular treatment models.

The editors offer advice on how to handle the associated issues within the therapeutic process and the impact on therapists who are oftentimes ill equipped to explore the spiritual dimension in a therapeutic setting. They provide an in depth discussion on transference when dealing with issues of spirituality and religion and draw a distinction between religion and spirituality.

The book is organized into three broad areas: 1. research on these areas, 2. clinical experience, and 3. recommendations to advance research and practice in the field. Meaning-making is highlighted in a few chapters, but I was very disappointed that Viktor Frankl, who is often referred to as the grandfather of meaning-making and the founder of logotherapy, was only mentioned once and not in an in-depth manner. In addition, forgiveness was mentioned only in one chapter and is a key component of any faith. Many research studies have demonstrated the healing powers of forgiveness after a trauma, in self-forgiveness and in forgiveness of family, siblings, and others who have caused them the trauma consciously or unconsciously. Although the book is focused on clients with trauma, much of the discussion is geared toward CBT approaches. The editors neglected to mention

other psychotherapeutic approaches to trauma healing, for example, other holistic and integrative modalities such as the 7-step Integrative Healing Model (the Biopsychosocial and Eco-Spiritual Model, Kalayjian, 2002, 2010) with its ecological and spiritual focus is not mentioned.

The editors provide guidelines and conclusions based on Christian spirituality and religion, which perplexes me as there are many therapists working with other religious and spiritual philosophies. Further research needs to focus on integrating other religions and holistic and integrative approaches to trauma healing.

I recommend this book as a resource for psychologists who like to integrate spirituality and faith in their practice - even if they do not work with trauma survivors - and for addressing issues of spirituality in their lives as well as in any therapeutic setting.

Dr. Ani Kalayjian, *a psychology professor at Teachers College Columbia University as well as at Meaningfulworld, a Psychotherapist, Genocide Scholar, International Humanitarian Outreach Administrator, Integrative Healer, author, and United Nations Representative. She was awarded University of Missouri-Columbia Humanitarian Award, the Honorary Doctor of Science degree from Long Island University (2001) recognizing 20 years as a pioneering clinical researcher, professor, humanitarian outreach administrator, community organizer and psycho-spiritual facilitator around the globe and at United Nations.*

Special gratitude to Natalia M. Tomassini, M.Ed.

Division 56 Member Services

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

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

Who's Who:
Beth N. Rom-Rymer, Ph.D.

We welcome Beth N. Rom-Rymer, PhD, as Division 56's new president. She brings a wealth of experience and dedication to the field, earning her numerous accolades, including the APA Presidential Citation awarded at the February 2015 Council meeting by APA President Barry Anton as well as Distinguished Psychologist Awards given by the Illinois Psychological Association in 2012 and 2014, and the Psychologist of the Year Award given by Division 31 in 2014. Let's get to know her better…

Beth N. Rom-Rymer, PhD

What is your current occupation?
I am a licensed clinical psychologist in Chicago with a private practice that includes forensic consulting on a national basis. I am the co-author of several publications, including "Practice Guidelines Regarding Psychologists' Involvement in Pharmacological Issues" (McGrath, et. al, 2011). Since 2002, I have been **a guest lecturer at the Northwestern Univers**ity Feinberg School of Medicine on the role of the forensic psychologist in the courtroom, the ethical responsibilities of psychologists who prescribe and/or consult on psychopharmacological issues, and the new prescriptive authority law in Illinois. I was also a faculty lecturer in ethics in the post-doctoral program in clinical psychopharmacology at the Massachusetts School of Professional Psychology from 2002 to 2007 and lecturer as adjunct faculty at the University of Chicago Pritzker School of Medicine's Department of Child and Adolescent Psychiatry from 1988 to 2001.

In addition, service to the profession comprises a significant part of my time. As a two-term president of the Illinois Psychological Association, I led the association's successful campaign for legislative prescriptive authority between 2011 and 2014 and I am currently leading the effort to implement and expand the 2014 law: Public Act 98-0886. With the passage of this law, healthcare is forever changed in Illinois. Prescribing psychologists will be seen as providing healthcare in every private and public health setting, becoming strong leaders in healthcare throughout the state. Now, other states are following suit. Since the passage of the Illinois law, more than 12 states have been actively and publicly preparing to pass RxP legislation. In the last several weeks, alone, Idaho psychologists have passed their prescriptive authority bill out of a State Senate Committee and the full State Senate and are awaiting a hearing in a House Committee; and Hawai'ian psychologists have passed their bill out of two state House Committees and out of their State House. They are now awaiting a hearing in the Health and Judicial Committee of the State Senate.

Among many other professional service positions: I have served two terms on the APA Council as a representative from Division 55; I have served as Chair and on the Executive Committee of several APA Council Caucuses; I am a Fellow of the Illinois Psychological Association and a Fellow of APA; and I was a member of the Board of Trustees of Alliant International University from 2009-2014, serving as Vice-Chair from 2012-2014.

Where were you educated?
I was a member of the first class of women at Princeton University, graduating with an A.B. in psychology in 1973. As pioneering women, many of us felt that we needed to achieve above and beyond what any man was achieving because we were continually expected to "prove ourselves." At the same time, because we were often the only woman in the room, we would be pointedly asked to talk about the "woman's" point of view. The experience was both exhilarating and challenging, and it gave me an extraordinary foundation on which to build my career. From Princeton, I went immediately to graduate school at The University of Illinois, Champaign-Urbana, where I earned my Ph.D. in clinical psychology (1987). I did my pre-doctoral clinical internship at the Vanderbilt University Medical Center.

Why did you choose this field?
One could say that the field of psychology chose me. When I was five years old, I had a conversation with my uncle about his work as a psychologist. Enchanted, I made a considered decision that I would become a psychologist. It also happened, during that year, that I was the "marriage counselor" when my friends and I played the game of "marriage and divorce" in the school playground during recess. When I was six years old, I had a dream that my soul was able to enter the minds of people throughout the world, and I was able to learn what people were thinking and why. My fate was sealed. From those tender years, I knew, with great confidence, **that I was going to be a psychologist**, and I set about reading all of the books I could find about our field.

When I entered Princeton as a freshman, I immediately declared my major. I worked with several brilliant mentors during my training, the first of whom was Carolyn Sherif, one of the social psychology giants of the 20th century. She trained me in being an astute observer of group dynamics, and discussed with me, inserting her personal anecdotes, all of the prominent social psychological theories of the 20th century through our time together (primarily 1972 - 1975). I later worked (1973 - 1975, 1980 - 1982) with Hobart Mowrer (APA President in 1954 and one of the foremost theoreticians and clinicians of the 20th century) who shared his personal psychological struggles with me and taught me the value of peer self-help while immersing me in the literature of integrity groups.

My work with trauma began during my internship at the Vanderbilt Medical School (1976-1977) and continues today, particularly in my forensic work. Because of my interest in working in the nexus of mental health and criminal justice, I created a rotation for myself with Carol Etherington, a Vanderbilt psychiatric nurse who was doing innovative group work with the survivors of sexual assault. Carol has subsequently made major contributions to world health care from her international work with Doctors without Borders. One component of her work involved training law enforcement in the most effective strategies to use when interviewing victims of violent crimes. The excellent and innovative training I received stood me in good stead when I went on to my first job as director of the Victim-Witness Assistance Unit in the State Attorney's Office in Tallahassee, Florida (1977-1979). In that position, I trained law enforcement officers throughout the state on the most effective strategies for interviewing victims of violent crime; I counseled victims of violent crimes; and I gave testimony to the courts as a counselor about the psychological status of my clients. I also co-founded a shelter that we named Refuge House for battered women and their children, and it recently celebrated its 36th anniversary. As director,, I was often a spokesperson for the State Attorney's Office to the media on issues involving interpersonal violence (sexual assault, incest, homicide, and spouse abuse) and victims' rights in the criminal justice system. With the two heinous murders and two near murderous assaults of Florida State University women students on January 15, 1978, I became very much involved in the notorious Ted Bundy case.

What is most rewarding about this work for you?
Some of the most rewarding parts of my work are that I "get it right." When conducting a forensic evaluation of a litigant, I take great pride in understanding the multiple complexities of the case and translating the complexities into language that attorneys, judges, and juries can understand.

Also rewarding are the many talks I give around the country about the Illinois and national movements for prescriptive authority for psychologists. It is a tremendous joy to see licensed clinical psychologists with advanced, specialized training in clinical psychopharmacology practice to the full extent of their training and significantly increase access to care for all of those citizens who are in underserved and mental health shortage areas (which happens to be the vast majority of counties in Illinois, including the largest county of Cook.)

What is most frustrating about your work?
One of the most frustrating parts of my forensic work is that some of the litigants whom I evaluate are not going to get the treatment that they so desperately need. They are often punished for criminal actions, but their mental illness is not considered and not treated.

Also frustrating to me are the lingering misconceptions that many psychologists have about the prescriptive authority law that was passed in Illinois in 2014. Some psychologists erroneously believe, for example, that legislation is a static process and that the constraints in our law are permanent. However, our legislative process is a dynamic, ongoing enterprise. Like all of the healthcare providers who have passed broader scope of practice legislation before us (optometrists, APN's, nurse anesthetists, podiatrists, physician assistants, licensed clinical counselors, midwives, etc.), we will continue to work with our state legislature to remove each one of the constraints in our law. This will take time, probably 10 to 20 years, but we will get it done.

How do you keep your life in balance (i.e., what are your hobbies)?
Balance? I'm always on the go! My hobbies include tennis, hiking, swimming, running, weight training, playing with my toddler grandson, traveling, seeing my daughter perform as an opera singer, and exploring new vistas.

What are your future plans?
I have a 20-year plan for the implementation and expansion of our prescribing law in Illinois to include providing training for hundreds of psychologists and enabling them to prescribe psychotropic medications. This will fulfill our commitment to the state of Illinois that prescribing psychologists will significantly increase access to care for the most vulnerable and underserved citizens of our state.

2015 Webinar Series Kicks Off to Record-Setting Attendance

By Grace Kao

To kick off Division 56's webinar series for 2015, Tyson Bailey, PsyD, hosted a workshop on "Working with Chronically Suicidal Clients: A Trauma Informed, Empowerment Focused Perspective." The webinar, which was held on Feb. 27, 2015, provided 68 participants with a thorough review of the fundamentals of suicide assessment and working with chronically suicidal individuals. Dr. Bailey, a licensed clinical psychologist practicing in Washington, is a certified suicide prevention trainer for Forefront (http://www.intheforefront.org/) and has been working with chronically suicidal clients since 2009.

The webinar focused on the clinical challenges and considerations of working with clients who regularly experience suicidal ideations and plans. Dr. Bailey discussed additional factors that may impact the development and course of chronic suicidality. Researchers have hypothesized links between implicit memories, early attachment experiences, and chronic suicidality, and Dr. Bailey addressed how implicit memories and trauma may affect fluctuations in suicidal ideation and suicidal/non-suicidal self-directed violence over the course of treatment. The webinar also conveyed the importance of consultation and documentation during the course of treatment.

On March 26, Kathleen Kendall Tackett, Ph.D. and Wendy Middlemiss, Ph.D. hosted the March installation of the webinar series for a record-breaking 89 attendees. The presentation, entitled "Early Adverse Experiences Increase the Risk of Adult Health Problems: The Implications of Lack of Responsive Care for Trauma and Long-Term Health," covered early responsive care and adult health implications. Dr. Kendall-Tackett, who specializes in women's health research, is a health psychologist, an International Board Certified Lactation Consultant, Fellow of the APA in Health and Trauma Psychology, and Past President of the APA Division of Trauma Psychology. Dr. Middlemiss is an educational psychologist who specialized in how to translate research to education, prevention, and intervention messaging.

The symposium consisted of Dr. Kendall-Tackett's discussion on health effects of early childhood diversity followed by Dr. Middlemiss's presentation on responsiveness to infant signals and implications of early autonomy. Overall, the presenters emphasized the importance of early experiences, intersections with biology, and how these factors relate to disease prevention in adulthood. Both psychologists shared important findings on how parent responsiveness is key in the development of healthy attachment patterns and physical well-being.

Recordings of all presentations will be placed in the Division 56 website archives within one month of the webinar date. Webinars will continue to be held on a monthly basis in 2015 except for the month of August. Links for registration and webinar fliers will be delivered via email.

Division 56 Member News

Robyn L. Gobin, Ph.D. and **Carolyn Allard, Ph.D.** received funding from the Clinical & Translational Institute at the University of California San Diego to test the efficacy of a new group-based intervention that focuses on emotion regulation and distress tolerance skills (PTSD-Prep) to increase the likelihood that individuals will optimally benefit from PTSD treatment. These treatment groups are specifically focused on Veterans who have experienced sexual assault or harassment while serving in the military (military sexual trauma; MST). Compared to other trauma survivors, Veterans with histories of MST are more likely to drop out of treatment early and continue to have PTSD symptoms following PTSD treatment (see Allard, et al., 2011; Eftekhari et al., 2013; Suris et al., 2013). The goal of PTSD-Prep is to: 1) teach Veterans skills for coping with painful emotions before they engage in treatment for PTSD; and 2) help them to engage in and benefit more fully from PTSD treatment.

Elizabeth Carll, Ph.D.

Elizabeth Carll, Ph.D. was invited to speak at the Commission on the Status of Women (CSW)- NGO Forum on Beijing+20 at the United Nations in Geneva, Switzerland in November. She spoke about the necessity for the integration of mental health into women's healthcare globally. As

the Immediate Past Chair of the United Nations NGO Committee on Mental Health, Dr. Carll participated on the team that successfully advocated for the inclusion of mental health in the outcome document. Dr. Carll will also be participating in a panel on women's health at the UN NGO CSW Beijing+20 Conference in March 2015 at the United Nations in New York.

Nathan Ainspan, Ph.D., Craig Bryan, and **Walter Penk, Ph.D., ABPP** are currently editing a Handbook on Psychosocial Rehabilitation. They hope the Handbook will be published by APA's annual meeting in Toronto, August, 2015. They believe such a handbook on psychosocial rehabilitation is needed because clinicians often concentrate on reducing symptoms, but overlook improving functioning when planning treatment (Twamley, et al., 2013). Chapters in the handbook are written by researchers summarizing the results from clinical studies and randomized clinical trials on such techniques as peer counseling, intensive case management, supported education, supported employment, family psychoeducation, physical exercise and nutrition, social skills training, and other techniques.

Carly Smith is working on finishing her dissertation, which examined the impact of institutional betrayal in healthcare on outcomes such as trust in healthcare providers and systems (e.g., insurance providers, hospitals), healthcare seeking behaviors and adherence to medical advice, physical health, and mental health. Over 2/3 of the sample of Mechanical Turk workers had experienced at least one type of institutional betrayal in healthcare in their lifetimes (e.g., a healthcare system that did not take proactive steps to prevent negative healthcare experiences; one that responded inadequately to reports of a negative experience). Institutional betrayal predicted lower trust, lower compliance with healthcare recommendations, worse physical health, more trauma-related symptoms (on the PCL-C), more dissociation, more depression, even when controlling for prior trauma and demographic factors.

Mindfulness-Oriented Interventions for Trauma: Integrating Contemplative Practices was recently published and edited by **Victoria M. Follette, Ph.D., John Briere, Ph.D., Deborah Rozelle, Psy.D., James W. Hopper, Ph.D.,** and **David I. Rome.** The book is grounded in research and accumulated clinical wisdom and describes a range of ways to integrate mindfulness and other contemplative practices into clinical work with trauma survivors. The volume showcases treatment approaches that can be tailored to this population's needs, such as mindfulness-based stress reduction (MBSR), acceptance and commitment therapy (ACT), dialectical behavior therapy (DBT), mindfulness-based cognitive therapy (MBCT), and mindful self-compassion (MSC), among others. Featuring vivid case material, the book explores which elements of contemplative traditions support recovery and how to apply them safely. Neurobiological foundations of mindfulness-oriented work are examined. Treatment applications are illustrated for specific trauma populations, such as clients with chronic pain, military veterans, and children and adolescents

Nora Baladerian, Ph.D., has shared information on how to best provide trauma treatment to children and adults with Intellectual and Developmental Disabilities (I/DD) and their families. The number of clinicians who provide such services is small compared to the need within the community. She has made a proposal within her state to develop a expertise since it has not emerged in the past 40 years. By designing the treatment to match the needs of children and adults with I/DD, and becoming familiar with the culture of disability, one can provide excellent services. By using the principles of trauma-informed care in the daily service delivery to those with I/DD trauma can be quickly identified and reduced, leading to rapid referral and treatment by a qualified provider. With her colleagues Dr. Sheila Mansell and Dr. Karyn Harvey, a chapter will be published this year in a professional tome updating child abuse treatment and response. The chapter delves into the issues faced by children with intellectual and developmental disabilities, and focuses on sexual abuse. Included in the chapter is information on the 2012 National Survey on Abuse of People with Intellectual and Developmental Disabilities that our organization sponsored. The results of the Survey that garnered over 7200 responses are summarized in the report they developed available on their website: disabilityandabuse.org/survey.

Beverly Ann Dexter, Ph.D. has taught Planned Dream Intervention to over 35,000 people world wide via in person and Skype and also has an Instructor Certification Program. In her book No More Nightmares: How to Use Planned Dream Intervention to End Nightmares & Instructor's Manual for Teaching Planned Dream Intervention she explains Planned Dream Intervention. She asserts this is a skill that can be easily learned, and is different from therapy designed to get rid of certain dream content. This book contains numerous examples of the type of successful interventions that have helped others start sleeping through the night, including those who experience intrusive Posttraumatic Stress Disorder (PTSD) nightmares. The book is also noteworthy with its explanation of how Planned Dream Intervention will help individuals who do not remember dream content, but wake up often despite otherwise good health. She suggests that if an individual learns Planned Dream Intervention they can usually experience an immediate release from the nightmares and start sleeping peacefully through the night.

Ani Kalayjian, EdD, DDL, BC-RN, BCETS, DSc (Hon), was awarded the Humanitarian Award, by the Advisory Board of the University of Missouri International Center for Psychosocial Trauma

(UMICPT) in November 2014. She also chaired an all day Meaningfulworld Humanitarian Outreach Training program in January of 2015, on Disaster Relief, Meaning-Making, and Emotional Intelligence. Furthermore, Dr. Kalayjian chaired an all day workshop on Conflict Transformation, Peace Building, and Forgiveness in February of this year. She has also organized a parallel event for the United Nations Commission of Status of Women on March 19th 2015 at the UN Chapel on Transforming Violence Against Women around the World in Africa, the Middle East and Caribbean.

Bethany Brand, Ph.D.

Bethany Brand, Ph.D. and her research team have created a website that provides educational resources about trauma for undergraduate and graduate students. The website is www.TeachTrauma.com, which offers trauma related slideshows, undergraduate and graduate course syllabi, classroom activities and assignments, textbook reviews, and many other resources. Some of the outstanding contributors include Judy Herman, Frank Putnam, Jennifer Freyd, David Spiegel, and Kathy Kendall-Tackett. Feel free to use the site's materials! If you would like to contribute material, contact Bethany Brand at bbrand@towson.edu. Dr. Brand also received an endowed professorship, the Martha Mitten Professorship, by Towson University. This award was given in recognition of her contributions to the trauma field in the areas of research, teaching and service. Dr. Brand plans to use the funds to support her research on dissociation and complex trauma, to develop the Frank W. Putnam Trauma Library, to expand the www.TeachTrauma.com website, and to host a trauma conference in Baltimore, Maryland.

Ilene Serlin, Ph.D.

Ilene Serlin, Ph.D. recently had a chapter published on Stanley Krippner's work with trauma: http://www.union-street-health-associates.com/articles/a-life-of-dreams-myths-and-visions.pdf. She also gave a talk on the use of the Expressive and Creative Arts Therapies to Work with Trauma at Stanford University in February of this year.

Marilyn Safir, Ph.D., Helene Wallach, Ph.D. and **Albert "Skip" Rizzo, Ph.D.** recently edited a new book entitled: Future Directions in Post Traumatic Stress Disorder: Prevention, Diagnosis and Treatment published by Springer.

L. Kevin Hamberger, Ph.D. and **Sadie Larsen, Ph.D.** recently completed a two-part, systematic review of 64 studies, published between 2002 and 2013, of men's and women's experience of intimate partner violence (IPV) in clinical samples. Both parts 1 and 2 are forthcoming in the Journal of Family Violence. Overall, the review found that while men and women in clinical samples are active participants in acts of physical IPV and emotional abuse tactics, women's physical violence appears to be more in response to men's. In addition, while men and women engage in emotional abuse tactics, types of abuse tactics differed. Men were found to threaten partner's life and limit partner autonomy while women were more likely to yell and shout. Further, men were found to be the predominant perpetrators of sexual abuse. Analysis of patterns of violence suggest that women are more highly victimized, injured and fearful, and they incur more costs from IPV than men in clinical samples. In addition, men were found to more frequently recidivate as suspects in IPV arrest cases, while women were more likely to appear in subsequent police reports as victims. Nevertheless, when identified as suspects, women and men appear equally likely to be arrested, particularly when potential confounding factors are controlled for. Areas needing more study include the development of gender-specific risk factor profiles, gender differences in the role of alcohol and drug use in IPV perpetration and victimization, and the role of gender in law enforcement and criminal justice decision making for ordering of restraining orders, arrest and prosecution. The article also discusses the clinical and research implications of their findings.

Bita Ghafoori, Ph.D. recently received a grant to start the second Trauma Recovery Center in California (and the first in southern California). The primary goal of the California State University Long Beach (CSULB)-Long Beach Trauma Recovery Center project is to create a comprehensive model of trauma and mental health care for victims of crime and their families while removing barriers to care for underserved victims of crime. CSULB includes a multidisciplinary group of community professionals, behavioral scientists and clinicians dedicated to providing education, services, and

treatment to underserved victims of violence. Training of graduate students and research are core components of the project. The trauma center team, which includes community based agencies St Mary Medical Center (level II trauma center), and CSULB work together with police, law enforcement, and academia to study best practices for violence intervention comprehensively and to provide evidence-based, actionable solutions for victims of violence, educators, industry, government and other stakeholders. Among the services the center provides are mental health services to victims of crime and their families; social services and medical patient navigation to victims of crime; comprehensive community outreach utilizing the expertise of established community based organizations; training to police; clinical case management; assistance with crime victim compensation documentation; and coordination of care between professionals serving victims of crime.

Jack Tsai, Ph.D. and colleagues recently published a study on posttraumatic growth in veterans. The study examined a nationally representative sample of veterans and found that a majority who reported posttraumatic stress also reported posttraumatic growth. Being socially connected, religious, and having a purpose in life was found to be associated with posttraumatic growth. Clinicians should consider the personal growth that can occur in trauma survivors. Reference: Tsai, J., El-Gabalawy, R., Sledge, W. H., Southwick, S. M., & Pietrzak, R. H. (2015). Posttraumatic growth among veterans in the United States: Results from the National Health and Resilience in Veterans Study. Psychological Medicine, 45(1), 165-179.

Social Media News

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

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

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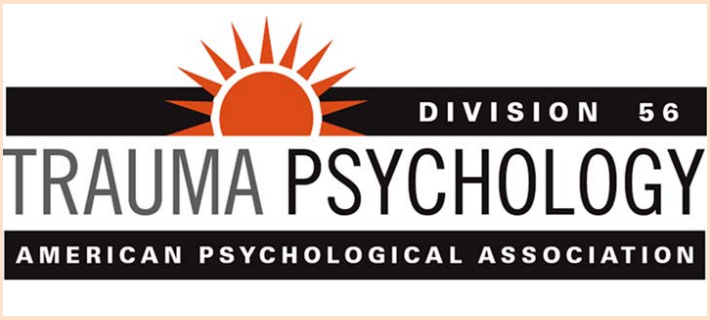

The TRAUMA PSYCHOLOGY NEWS is a membership publication of the Division of Trauma Psychology, Division 56, of the American Psychological Association and, currently, produced three times a year. The newsletter provides a forum for sharing news and advances in practice, policy, and research, as well as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

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

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

PUBLICATION SCHEDULE

Issue	Submission Deadline	Publication Date
Spring	February 1	April
Summer	June 1	July
Fall	October 1	November

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

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

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

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

DIVISION 56 LOGO INFORMATION

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