



DIVISION 56

# TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

## NEWS

### PRESIDENTIAL VOICE

## Trauma Psychology: Getting the Word Out

By: Joan Cook, PhD

We have accomplished so much in a relatively short period of time. In 2006, the

Division of Trauma Psychology was started with 901 members. Since then, we have grown as well as deepened and broadened our roots. At our 10th year anniversary, we are one of only five divisions to increase membership in the last year, and we are still growing. We are indeed among the most vibrant of all divisions although we are the youngest.



Joan Cook, PhD

In just under 10 years, we have created a dynamic and flourishing permanent home within the American Psychological Association (APA) for scientific research, professional and public education, and the exchange of support for activities related to trauma. We have a strong track record of high quality programming at the APA Annual Convention, our journal *Psychological Trauma, Theory, Research, Practice and Policy* has a strong impact factor, our news-

letter and recently revised website continue to provide helpful resources, and we held a consensus conference on competencies for working with trauma survivors which were

approved by the APA Council of Representatives in August 2015 and are now become official APA policy (<http://www.apa.org/ed/resources>).

Our members, with their rich and diverse collection of knowledge and interests across the domain of psychological trauma, have helped us to accomplish this and so much more. Besides an incredible member-

ship that forms the base of our Division, we have had wonderful leadership. I particularly want to thank all

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**Elected Positions by the Division****President**

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**President-Elect**

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**Past-President**

*Beth N. Rom-Rymer, Ph.D.*  
Rom-Rymer and Associates  
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**Secretary (3 years, renewable for one term)**

*Amber N. Douglas Ph.D.*  
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Department of Psychology of Education  
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**Treasurer (3 years, renewable for one term)**

*Lisa Rocchio, Ph.D., Chair*  
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**Council Representative from Division 56 to APA (3 years, renewable for one consecutive term)**

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**Council Representative from Division 56 to APA (1 year, completing Joan Cook's term)**

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**Early Career Psychologist Representative to Division 56 EC (2-year term, renewable for one consecutive term)**

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**Members-at-Large to Division 56 EC (3 years, renewable for one consecutive term)**

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**Position Selected by President and Search Committee:****Journal Editor, Chief**

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**Positions Selected by Journal Editor-in-Chief****Journal Editors, Associates (1 year with auto renew, not past 2020)**

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**Standing and Ad Hoc Committees (1-year term, renewable if appointed by incoming President)****Awards Committee**

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**Convention Program Committee**

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**Disaster Relief Committee**

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**Diversity and Multicultural Committee**

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**Other Individual Appointments:****Listserv Manager (appointment by the President and confirmed by EC, renewable every year)**

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**Web Editor (appointed by the President and confirmed by EC for 3-year term, renewable for two terms)**

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**Task Forces (President selects)****Developing Web-Based Trauma Psychology Resources Task Force**

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**Addressing Trauma in General Medical Health Settings Task Force**

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**Meeting the Needs of Veterans in the Community Task Force**

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**Developing Benchmarks for Measuring Competence in Trauma Psychology Task Force**

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**Child Trauma Task Force**

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**Capital Campaign Task Force**

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**Interrogation Task Force**

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**Mental Health Apps Review Task Force**

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**Update and Complete the Policies and Procedures Manual Task Force**

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**Complex Trauma Task Force**

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**Recovered Memory Task Force**

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## Presidential Voice

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of our past presidents: Drs. Judie Alpert, Bob Geffner, Steve Gold, Laura Brown, Chris Courtois, Terry Keane, Constance Dahlenberg, Kathy Kendall-Tackett, and Beth Rom-Rymer for their endeavors to make our Division strong. At this year's Convention, we are planning to not only have a happy 10th anniversary celebration but an opportunity for our membership to hear from all of our past presidents in an engaging discussion format.

My presidential theme for our division this year is: "Trauma Psychology: Getting the Word Out." We have done a fantastic job in getting the word out thus far and telling APA members that there is a home for those who work in or are interested in the trauma field. But more work needs to be done! Getting the word can mean so many things - it means getting the word out about our group and increasing membership. It means getting our current members more involved in our activities (e.g., convention programming, webinars, etc.). It means getting the word out to a broad audience through our journal, including policy makers and the public.

Although our Division is open to all psychologists and students in the APA, I suspect there are many psychologists with an interest in trauma who are not yet members but are eager for a home base. Let's welcome and show them that our Division is a professional home to many – a broad range of researchers, practitioners, theorists, and policy makers. In addition, there are other divisions and organizations where trauma is a key issue. Let's invite them to join or partner with us on important endeavors. For example, we recently received a small APA grant to create web-based materials on trauma for underserved populations and we are doing so in partnership with five other APA divisions.

Our Division is also open to those who may not belong to APA, and to professionals in other disciplines as affiliate members whether or not they are APA members. Let's continue to put our best selves forward and collaborate in the spirit of helping trauma survivors, their families and communities and the professionals who serve them.

In order to increase diversity and representation as well as share opportunities and responsibilities, I have invited some new faces to join us in leading the division. The incoming executive committee is strong and dedicated, and will continue the solid foundation that has been built for our Division.

As one of my first orders of business, I am delegating several task forces to help get the word out—each of these task forces will be featured in current or future issues of our newsletter, *Trauma Psychology News*. Until then I want to encourage all of you to also get more involved in the division and to please recruit others to join so that we can continue to increase not only our numbers

but build our influence within and outside of APA. It would be wonderful if each of us could commit to bringing one new colleague into our fold this year. I remember a few years back hearing Chris Courtois talk about how she carried around Division 56 membership forms (available from the membership committee, on the web site, or here in the newsletter) and distributed them at her training workshops. She also put the Division logo and our web address on her PowerPoint slides so that everyone could see where she made her home. I respectfully ask you to do the same.

In addition to recruiting new members, I invite you to become more involved: join a special interest group (SIG), submit an article for the newsletter or journal, attend the outstanding trauma sessions scheduled at the APA Convention both in the regular program and at our hospitality suite program, participate in our incredible webinars, serve on a committee, or nominate yourself to run for elected positions. With our 2016 convention chair, Amy Ellis, and our hospitality suite chair, Vanessa Simiola, I am working to create a notable convention for us in Denver! Convention will be from Thursday, August 4th to Sunday, August 7th. So please mark your calendars, plan to attend and join us for our 10th year anniversary party!

Sooner or later the rhythm of Division 56 is going to get you. Why not get on your feet and make it happen today?

I look forward to an exciting and productive year for our Division. Thank you so much for the opportunity to serve as president. Please feel free to contact me (Joan. Cook@yale.edu) if you have questions or concerns, or to share ideas or suggestions for accomplishing our goals for 2016.

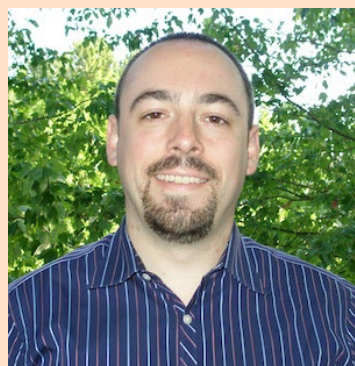




# A Change in Presidents



*Bryan T. Reuther, Psy.D.  
Editor-in-Chief*



*Tyson Bailey, Psy.D.  
Associate Editor*

Dear Colleagues,

**H**ope everyone's year is off to healthy and productive start! To begin, I would like to thank Dr. Beth Rom-Rymer for her poise, diligence, and leadership during her tenure as president. Her guidance with navigating the fallout from the Hoffman Report, as well as the many other initiatives she advanced certainly captures the essence of her hard work and commitment to Division 56 and the trauma survivors we help.

I'd also like to formally welcome Dr. Joan Cook as president of Division 56. In her first few short months as president, she has already put together several task forces, some of which are outlined in this publication. I encourage each of you to check them out, and become familiar with Dr. Cook's initiatives as well as the accomplished clinicians and researchers selected to be at the helm.

We feel this is a really exciting issue, as it contains articles on diversity issues, measuring trauma informed care, and applied practice, alongside webinar information, a memorial, book review, a stimulating interview by our international committee, and news/announcements about the superb work of our fine members. And, of course, please get to know our very own Dr. Tyson Bailey in the Who's Who section! Enjoy!

All the Best,

Bryan T. Reuther  
Editor-in-Chief

## Division 56 Member Services

**Join Division 56:** [www.apa.org/divapp](http://www.apa.org/divapp)

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

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

**Website:** [www.apatraumadivision.org](http://www.apatraumadivision.org)

**Listserves:** Everyone is added to the announce listserv, [div56announce@lists.apa.org](mailto:div56announce@lists.apa.org) (where news and announcements are sent out; membership in Division 56 is required).

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

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

**Newsletter:** The newsletter is sent out on the division listservs and is available on the website at [www.apatraumadivision.org/207/division-newsletter.html](http://www.apatraumadivision.org/207/division-newsletter.html)

**Membership Issues:** Email [division@apa.org](mailto:division@apa.org) or phone 202-336-6013.

# Division Officer Elections: April 15 to May 30

## PRESIDENT-ELECT

### Diane Castillo

I am honored to be nominated for president of Division 56, Trauma Psychology. I am committed to continuing the strong leadership tradition psychologists have made in the field of trauma and would appreciate your support. I have dedicated my career to the field of trauma for 28 years as a clinician, researcher, educator, leader, and administrator. I was the Division 56 Diversity Member at Large Chair for 4 years and Co-Chair in 2015, as well as served on the Board of Directors for ISTSS, which has given me experience in governance. My clinical, research, and administration experience has



been in the VA, where I developed programming for the treatment of PTSD in male and female Veterans using Evidence-Based Psychotherapies (EBPs) and as one of 18 national trainers for Prolonged Exposure therapy through the National Center for PTSD. My PTSD research includes the clinical application

of EBPs as PI on randomized controlled trials and Site Investigator in national PTSD studies. I am an Associate Editor for Psychological Trauma and served as Guest Editor on a special PTSD issue in the journal Behavioral Sciences. I have provided PTSD trainings locally and nationally and have presented professionally at APA, ISTSS, and IVAT. I have supervised trainees at all levels and assisted in the development of national training videos on the treatment of PTSD in special populations/issues (Hispanic, women, PE). I believe I have the governance experience and trauma background to continue the advancements as president of Division 56. Thank you for your consideration.

### Sylvia Marotta-Walters

As a charter member of the Division, I am honored to be considered for president of the division. The division has accomplished so much in a short period of time. I've had the privilege of serving in various roles over the years, including chairing a task force on interpersonal violence, serving as liaison to the National Partnership to End Interpersonal Violence, as program co-chair and chair for two years, on the practice committee, and currently as associate editor of our *Psychological Trauma* journal. My focus, should I be fortunate enough to be elected



president, would be to work so that a trauma-informed lens would shape the work of all health care providers, and for professional psychologists, I would build on the excellent work of the initial group that developed the trauma competencies and made the division strong.

The world we are living

in continues to produce experiences of extreme stress for the public, and I believe that practitioners need to be trained and educated in these competencies so that they can provide the best interventions possible for an increasingly stressed and vulnerable population. Now that the competencies have been accepted by APA at the initial level, the division needs to determine whether a proficiency, or a sub-specialization, is the next step. Whatever the path the division decides to take, I would build on the excellent work that each president has contributed to the field of trauma and to those who suffer from it.

### George Rhoades

I would be honored to serve as President-elect of Division 56. A Founding Member of the Division 56 Executive Board and having Native American and African American heritage it was an honor to serve as Co-Chair of the Diversity Committee. As past Chair Education and Training Committee and Chair Continuing Education Committee, we started the successful webinar series and obtained CE accreditation for the Division. I am also on the Editorial Board of *Psychological Trauma*, our Division Journal.



A practicing Clinical Psychologist since 1984 and Founder and Director of Ola Hou Clinic in Hawaii, providing supervision for Graduate Students at the Masters and Doctorate Levels. An international trauma speaker and author, conducting trauma trainings/Consultations/Counseling

for professionals and community leaders in over 28 countries, recently focusing on Syrian Refugees internationally. Executive Director of "Roads to Hope" and Director

of Clinical Training for “Global Aid Network-Canada,” both humanitarian missions to help remove the barriers of trauma.

I am a Fellow with International Society for the Study of Trauma and Dissociation and served on their Executive Council. International Expert on Sexual Trafficking and Clinical Director for Ho‘olanapua, residential program for teenage girls rescued from sexual trafficking. Past Director of an JCAHO Inpatient Program for children, adolescents and adults at Kahi Mohala Psychiatric Hospital. Past Professor of Psychology and Chair, Psychology and Counseling Program at International College and Graduate School.

I would be honored to help Division 56 to continue the standards of excellence in academic, clinical and international work in trauma psychology.

## **TREASURER**

### **Melanie Hetzel-Riggin**

I am honored to be nominated for Trauma Psychology Division’s Treasurer position. I am an Associate Professor of Psychology at Penn State Erie, The Behrend College. I graduated with my Ph.D. in Clinical Psychology



from Northern Illinois University and trained as part of the Center for Family Violence and Sexual Assault. My research and clinical work has focused primarily on risk and resiliency factors associated with interpersonal violence (including sexual assault, dating/ domestic violence, child abuse, and peer mistreatment). I also will

be serving as the Program Coordinator in my college’s new Master’s program in clinical psychology with a focus on trauma-informed treatment. In addition to teaching, academic publishing, serving as a manuscript reviewer for numerous clinical and trauma-related journals, and grant writing, I have worked closely with local victim services and law enforcement to improve responses to survivors of interpersonal violence.

I believe it is my responsibility to give back to the Division that I consider my professional home. I am particularly passionate about two issues: prevention and training. If elected, I would help the Division seek out ways to disseminate our work to groups and agencies to improve the prevention of traumatic stress. I would also like to see the Division work towards developing best practices for training therapists in trauma-informed care, as well

as increase ties with related professions who work closely with trauma. If elected, I promise to fulfill my responsibilities with passion and devote myself to furthering the mission of the Division.

### **Lisa Rocchio**

I am honored to run for a second term as Treasurer of Division 56, where I am a founding member and liaison to APA’s Committee on Women and Psychology. In my role as your Treasurer, I bring my expertise as a clinical and forensic psychologist who specializes in the areas of interpersonal violence, traumatic stress and ethics. In



addition, I am highly experienced with organizational financial management. Specifically, I am the founder and Director of Lisa M. Rocchio, Ph.D. & Associates, Inc., an inter-professional practice providing services to adults, adolescents, children, and families. As a business owner, I supervise clinical

and administrative staff, create and manage financial, business, and clinical policies and procedures, and collaborate with other professionals, hospitals and agencies throughout the state. In addition, I am the current APA Council representative and former president of the Rhode Island Psychological Association and have served as Chair of the APA Committee for State Leaders. In my various positions, I have consistently proven myself to be a fiscally responsible and dynamic leader. I am active within local, national and international Trauma Psychology organizations, was selected to participate in the APA Leadership Institute for Women in Psychology, and am an executive member of the Board of Trustees of an independent Quaker school.

I am strongly committed to the field of Trauma Psychology, and have published, presented, and taught on topics related to trauma, ethics, forensic psychology, and professional practice. I welcome the opportunity to continue my service to Division 56.

## **COUNCIL REPRESENTATIVE**

### **Lore Dickey**

It is an honor for me to be considered to serve DIV 56 as a Council Representative. I am a new member of Trauma Psychology. I am also an Early Career Professional. However, I am not new to APA governance. I have served the profession on the APAGS Committee and have served in leadership roles for DIV 44 (Society for Psychological Study of LGBT Issues) and DIV 17





(Society of Counseling Psychology).

My clinical and research work is focused on understanding the lives of transgender people. I recently finished serving as a co-chair of the APA Task Force that wrote the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*. In my work with transgender people I often see the many ways that simply living as an out trans\* person often subjects a person to trauma. I hope to further my work in understanding the trauma experiences faced by the trans\* community.

When I was asked to serve as a Council Rep for DIV 56 I did so with the hope that I could bring a fresh perspective to APA Governance. Although I have never served on Council, I believe I have the analytical skills and devotion to the profession to serve DIV 56. I believe, as many of you do, that it is time for a shift in the ways that APA makes policy decisions. I would like to be part of that reform process. Thank you for considering my candidacy for Council Rep.

**Steve Gold**

I am honored to be currently serving Division 56 on the APA Council of Representatives (COR) and to have been nominated to continue in this capacity. My support of Division 56 dates back to the first meeting of APA members interested in forming a trauma psychology division. I served as the Division's APA Convention Program Chair, as Division 56 president, and from 2008 through 2014 as the first editor of the Division's journal, *Psychological Trauma*.



It has been tremendously exciting to see the Division grow into a vibrant and highly respected home for professionals interested in trauma.

Serving on COR has taught me a great deal about APA system-wide and about Division 56's potential role in the larger organization. It takes time to become familiarized with the workings of COR. My current term has taught me a great deal in this regard.

This is a pivotal time for APA. While the organization is strong in many ways, its reputation has been marred by the circumstances surrounding the Hoffman report. In addition, APA membership has been steadily shrinking; APA is not adequately attracting the full range of diversity represented by psychologists. I see these trends as being related to a drift by APA away from a sufficiently strong emphasis on core values such as ethics, human rights and social justice. If re-elected I promise to continue to be a strong voice on COR for support of these values and of the interests of Division 56.

## MEMBER-AT-LARGE

### Divya Kannan

I received my doctorate in clinical psychology in 2012 from the University of Memphis and completed my



pre and post-doctoral training at Vanderbilt University. As Assistant Professor of Clinical Psychiatry at the Vanderbilt University Medical Center, my interest in working with trauma survivors, being involved in trauma-focused research and writing, and assuming leadership positions in this area has inspired

much of my work as a psychologist. I enjoy my role as leader of the trauma team at the Vanderbilt Psychological & Counseling Center and have worked on our team's development and implementation of an evidence-based, trauma-focused program of care and meeting the acute needs of students after trauma exposure. Additionally, I am glad to have the opportunity to be a member of the editorial team for the developmental traumatology column for the ISTSS Stress Points newsletter, an experience that has been fulfilling as I share my thoughts and interact with professionals within this community.

My interest in the Member-At-Large position would help me continue to grow professionally and to contribute to the aims of the Division 56 executive committee. One specific way I would like to contribute, is a project idea that I am excited about, which is to examine existing treatment models of trauma-informed care within universities across the nation. Through qualitative methods of inquiry, this research can produce important guidelines around the barriers and facilitative agents to psychological care for students impacted by sexual assault, particularly in the context of the current campus climate.

## Nnamdi Pole

As a founding member of Division 56, I was appointed to Chair a Task Force Examining the Traumatogenic Aspects of the Bush Administration's Enhanced Interrogation Program. We worked for more than a year to produce a 2008 report that showed that "enhanced" interrogation can lead to lasting harm tantamount to torture. I am proud of the fact that Division 56 was way ahead of the Hoffman Report in raising concerns about enhanced interrogation. I have also served as guest co-editor of a special issue of the division's journal, *Psychological Trauma: Theory, Research, Practice, and Policy*. Our issue highlighted many ways that race and ethnicity complicates our understanding of traumatic stress. It also set a tone for what has been an ongoing commitment of the journal to maintain a multicultural perspective. Last year, I served as Chair of the Convention Program Committee. In that capacity, I worked closely with President Beth Rom-Rymer to develop programming around the theme of trauma and social justice. Our program had many highlights including an examination of transgenerational trauma in several ethnic groups, a discussion of the Black Lives Matter movement, and a fantastic keynote address by Bryan Stevenson. I am currently Co-Chair of the Awards Committee with Bitia Ghafoori. As member-at-large, I hope to continue to represent my "professional home" in Division 56 with honor and distinction. I am tremendously proud of all of the ways that our Division has set and exceeded standards within APA. I would endeavor to maintain and enhance our reputation.



## PROFESSIONAL AFFILIATE REPRESENTATIVE

### Christopher Anderson

As are more than half of people in the United States, I am a survivor of trauma and abuse. From the age of 5 I began what has become a lifelong partnership as a survivor with mental health professionals. Some of the clinicians I met did not understand trauma. These interactions often left me feeling more confused and



hurting. These negative experiences were little more than a set of bad memories until I attended my first Male-Survivor Weekend of Recovery. There I met and worked with clinicians who "got" trauma for one of the first times in my life. The lessons they shared with me changed the direction of my life.

Ever since that weekend, I have been passionate about connecting survivors and professionals to build stronger partnerships. In 2007 Dr. Steven Gold attended my first presentation on this topic, "Ten Things Therapists Should Know About Male Survivors of Sexual Abuse," and his support empowered me to keep at it. Since that time I have trained thousands of clinicians, social workers, law enforcement, and other professionals to help them better understand trauma from the survivor's perspective.

In 2012, I was named the first Executive Director of MaleSurvivor, and have worked hard to continue building bridges between survivors and the professional community. It would be an honor to continue this work by being officially accepted as a partner of this division.



# Addressing Social Marginalization and Health Disparities in Trauma Psychology

By: Bekh Bradley, PhD and Lesia M. Ruglass, PhD

A robust body of research demonstrates that social marginalization resultant from the intersection of multiple factors including race and ethnicity, gender, sexual orientation, gender expression, disability, immigration status, and socioeconomic status is associated with disproportionate risk of exposures to stress and trauma and increased vulnerability to its impact (Brown, 2008; Ford, 2008; Pole, Gone, & Kulkarni, 2008). For example, studies indicate women are twice as likely to develop PTSD compared to men, likely due to their greater exposure to high impact traumas (e.g., sexual violence) as well as gender-specific psychological and biological peri- and post-trauma reactions that confer greater risk for developing PTSD (Olf, Langeland, Draijer, & Gersons, 2007; Tolin & Foa, 2006). Likewise, studies indicate elevated post-traumatic stress reactions and risk for PTSD among sexual minority youths compared to their heterosexual counterparts, mediated by disparities in exposure to violence beginning early in childhood (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). These findings highlight the urgent need for social, psychological, and legal interventions designed to ameliorate the detrimental effects of trauma among vulnerable populations.

These issues were central in a lawsuit recently filed against the Compton Unified School District (CUSD; *Peter P. v. Compton Unified School District*, 2015) in an attempt to require the school district to address the needs of students who have been impacted by trauma. The lawsuit notes that students in this school district are “routinely” exposed to high levels of trauma, the impact of which is exacerbated by poverty, racism, and oppression based on gender and gender expression. The absence of a systematic effort by the CUSD to take steps to mitigate the impact of pervasive trauma and stress—even though models for this type of intervention exist—is, in part, related to our current medical perspective on the impact of trauma, an

understanding that is not well informed by sociopolitical factors and that does not include a social justice perspective.

What steps can be taken towards making improvement in this area? We might start with broadening our understanding of “trauma” in a way that takes social, cultural, and political factors into account. Consideration needs to be given to expanding the definition to include historical trauma and intergenerational trauma (Bowers & Yehuda, 2016; Evans-Campbell, 2008; Perdue et al., 2012). We also need to consider sociocultural risk and protective factors such as cultural values and beliefs, immigration status, acculturation, socioeconomic status, racism, and discrimination (Ford, 2008; Marsella, 2010). Furthermore, we must acknowledge the importance of psychosocial and political power in determining risk for exposure to trauma, its impact on health and the availability and utilization of appropriate interventions (CSDH, 2008). Taking these steps would help turn away from an ahistorical approach focused primarily at the level of the individual.

Our approach to the treatment of trauma related psychological problems needs to draw upon broader, cross-cultural understandings of health and approaches to healing. An example of this is the medical anthropology work examining Nepali beliefs about trauma (Kohrt & Hruschka, 2010) and work by Marsh and colleagues (Marsh, Coholic, Cote-Meek, & Najavits, 2015) in developing a model of treatment that blends traditional Aboriginal approaches to healing with Western approaches to support healing from intergenerational trauma and substance use disorders among aboriginal peoples. We need to take action in collaboration with communities impacted by trauma. This type of response to trauma is highlighted in the CUSD case, which identifies characteristics of a “trauma sensitive school” including training and coaching educators to recognize and address the effects of trauma among students, creating a safe, positive and predictable school environment, imple-



*Bekh Bradley, PhD*



*Lesia M. Ruglass, PhD*

menting resilience focused interventions, development of practices that support healthy relationships including methods for peaceful conflict resolutions, and using restorative justice and other non-punitive approaches to discipline. These types of approaches can be applied in a variety of settings (e.g. schools and prisons), as well as within neighborhoods.

It is important to address unmet need for treatment and barriers to access and utilization of treatment services across diverse populations. Strategies to reduce barriers may include increasing access to trauma-informed programs; additional training in multicultural competence among service providers; increasing multicultural programs and staff; and matching of clients and therapists if preferred and feasible (Brown, 2008; Carter, Mitchell, & Sbrocco, 2012; Ford, 2008; Marsella, 2010; Roysircar, 2009). Empowerment of disenfranchised and marginalized individuals and communities in both research and practice is also a key aspect in mitigating trauma's impact (Cattaneo & Goodman, 2015). One way this can be done is by developing interventions implemented by community members. In addition, we need more research and interventions centered on the perspectives of marginalized individuals and giving voice to these perspectives. An example of this type of work is photovoice or participatory photography methods (Wang & Burris, 1994), which combine social activism and photography with the goal of giving voice to marginalized perspectives (Crabtree & Braun, 2015). A truly sociopolitical framework for understanding trauma and mitigating its impact will require a social justice perspective and it will be grounded in actions addressing the structural inequalities that contribute to health disparities.

### Division 56 Activities

The Diversity and Multicultural Committee's mission is to enhance awareness of the prevalence, consequences and treatment of trauma (traditional, indigenous, complementary, and alternative practices) among diverse populations (e.g., by Age, Sex/Gender; Race/ Ethnicity; Culture; Sexual Orientation; Disability; SES; International) utilizing a social justice framework. To this end, we have created seven workgroups tasked to create factsheets with the most up-to-date research on trauma exposure, risk and protective factors, PTSD and other trauma-related disorders, and treatment among diverse/multicultural populations. We hope these guides can serve as resources to communities, clinicians, and researchers. We plan to liaise with and help support the efforts of the greater APA body and international organizations on their work pertaining to diversity and multicultural issues. We also plan to develop international fieldwork placements in trauma psychology to help support efforts at the global level and provide much needed training opportunities for students/clinicians who wish to pursue this line of practice.

Members interested in getting involved in the Diversity and Multicultural Committee can do so in several ways: 1) join a workgroup and assist with the creation of resources for dissemination; 2) contribute an article to the diversity and multicultural issues column; 3) monitor our efforts and assist as you can. Contact us at [rbradl2@emory.edu](mailto:rbradl2@emory.edu) and [rugglass.ccnny@gmail.com](mailto:rugglass.ccnny@gmail.com) for more information.

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**Bekh Bradley, PhD** received his BA in psychology from Wesleyan University in 1993 and his PhD in Clinical Community Psychology from the University of South Carolina in 2000. Dr. Bradley is an Associate Professor in the Department of Psychiatry and Behavioral Sciences at Emory University. Dr. Bradley has significant experience in clinically and empirically grounded research on PTSD and trauma. Though his clinical work, research, teaching and leadership responsibilities, Dr. Bradley is dedicated to providing outstanding clinical care and to increasing knowledge of factors contributing to risk and resilience following trauma exposure.

## Measuring Trauma-Informed Care: The Attitudes Related to Trauma-Informed Care (ARTIC) Scale

By: Steven M. Brown, PsyD and Courtney N. Baker, PhD

In recent years, the push to implement trauma-informed care (TIC) has increased dramatically across a wide variety of sectors including mental health, substance abuse, child welfare, education, corrections, primary care, and youth development. In addition, whole cities are implementing TIC (e.g., <http://www.peace4tarpn.org/>). TIC is defined as service delivery that recognizes the profound biological, psychological, and social sequelae of trauma with the goal of ameliorating, rather than exacerbating, its impact (Harris & Fallot, 2001). Entire systems of care are now working to become trauma-informed, grant applications are requiring organizations to address how they will provide services in a trauma-informed manner, state legislation is being considered to mandate TIC in schools, and there are calls to rigorously evaluate TIC as part of implementation monitoring, quality assurance, and research. The ultimate goal is to gather and use empirical data on TIC to promote widespread and sustainable adoption (Cole et al., 2013; Ko et al., 2008; SAMHSA 2014).

This growing interest in TIC has led to a upsurge in implementation and practice models. However, practice is far ahead of science with respect to defining and operationalizing TIC phenomena, identifying critical elements of the trauma-informed change process, and rigorously evaluating TIC efficacy and effectiveness. Unfortunately, numerous barriers exist to research on TIC, including the description of TIC varying widely

across the emerging literature, resulting in an operational definition that is unclear. For example, a recent literature review revealed 19 recent publications articulating TIC frameworks, most being literature syntheses, white papers, or theoretical writing (Baker, Brown, Wilcox, Overstreet, & Arora, 2015). On the implementation front, systems are hungry not only for clear implementation blueprints, but also for the evidence that supports them. In short, the TIC field is primed to move from fruitful theoretical and conceptual thinking to data-driven analysis.



Steven M. Brown, PsyD

One major impediment to forward movement is the absence of psychometrically robust instruments to evaluate TIC. The empirical work on TIC, while limited, generally measures the impact of implementation through client-reported outcomes (Morrissey et al., 2005); program level data such as restraints and seclusions (Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011); and organizational-level features such as treatment environment (Rivard, Bloom, McCorkle, & Abramovitz 2005). While these are vital outcomes, they are costly and time-consuming to collect and evaluate. Because so many factors can influence these distal metrics, it is difficult to know whether TIC

implementation was the factor related to the change. Organizations often report anecdotal evidence of change, but they struggle to find practical tools to capture this change quantitatively. In response to this need, we developed and evaluated the Attitudes Related to Trauma-Informed Care (ARTIC) Scale.



## Development and Psychometric Support of the ARTIC

The ARTIC was based on an earlier 19-item measure developed for program evaluation of the Risking Connection® (RC) staff trauma training model (Brown, Baker, & Wilcox, 2012; Saakvitne, Gamble, Pearlman, & Tabor Lev, 2001). The ARTIC evaluates attitudes, which are understood as a primary driver of the moment-to-moment, day-to-day behavior of its personnel and thus foundational to any trauma-informed system (Ajzen, 1991; Fixsen, Blase, Naoom, & Wallace, 2009; Kirkpatrick, 1967; Metz, Blase, & Bowie, 2007). The original instrument was limited in that it included only one general factor. To address the limitation, we embarked on an extensive mixed methods process to revise the measure, involving a review of the theoretical, empirical, and measurement literatures relevant to TIC and utilizing a community-based participatory research approach (Hausman et al., 2013).

Items were written to characterize a TIC-favorable attitude and were then paired with the opposite attitude. For example, the item “the clients I work with are doing the best they can with the skills they have” (favorable) is paired with “the clients I work with could act better if the really want to” (unfavorable). All items use a seven-point bipolar Likert scale. ARTIC items were evaluated using a sample of 760 service providers, including 595 who worked in human services, community-based mental health, or health care and 165 who worked in schools. A little over half of participants reported having previously participated in formal TIC training (e.g., Risking Connection, Advocates for Children, Sanctuary).

Item analysis and confirmatory factor analysis supported three ARTIC versions: the ARTIC-45, ARTIC-35, and ARTIC-10. The ARTIC-45 is a 45-item measure with seven total subscales, including five core subscales (i.e., underlying causes of problem behavior and symptoms, responses to problem behavior and symptoms, on-the-job behavior, self-efficacy at work, and reactions to the work) and two supplementary subscales (i.e., personal support of TIC and system-wide support for TIC) and an overall score. The ARTIC-35 excludes the supplementary subscales for those systems that have not yet implemented TIC. The ten-item short form, called the ARTIC-10, provides one overall score derived from the five core subscales. Internal consistency reliability was good to excellent (as = .82-.93) for the three ARTIC versions, and subscale alphas ranged from respectable to very good (DeVellis, 2012). Temporal consistency was strong, with

correlations of  $r = .84$  at  $\leq 120$  days,  $r = .80$  at  $\leq 121$ -150 days, and  $r = .76$  at 151-180 days for the ARTIC-45. Associations among ARTIC subscales and numerous validity indicators suggest construct and criterion-related validity. Several investigations to further support validity are now underway. For more information about the study method and findings, please see the full article (Baker et. al., 2015).

## Study Implications

Stakeholders in the burgeoning TIC movement have started to ask what concretely trauma-informed care means, how one operationalizes it, and how one knows TIC is truly being practiced. For example, some organizations offer periodic trainings or evidence-based trauma treatments for individual clients and understand that as meaning they are “trauma-informed.” However, the field lacks an objective way to determine the extent to which an individual or system is trauma-informed. The ARTIC was developed to address this gap by measuring one important element of TIC – service providers’ attitudes related to TIC. We anticipate that the use of the ARTIC will also spur the field to identify what is and is not trauma-informed and to progress beyond what are currently important but vague principles underlying the movement.



*Courtney N. Baker, PhD*

Because of the widespread applicability of TIC to educational, human service, corrections, and medical settings, the ARTIC has many possible uses. Organizations that have never implemented TIC could use the ARTIC to assess their “readiness” to embrace innovation (Weiner, 2009). They can also use it as a baseline measure to determine the extent to which their culture is trauma-informed, and how it changes as result of intervention. For organizations that have implemented TIC, the ARTIC can provide a way to engage in ongoing evaluation of system-wide TIC practices that are hypothesized to be associated with better outcomes.

Experts in trauma-informed system change argue that, while TIC is difficult to implement, it can be even harder to sustain due to pressures that act as a “gravitational pull toward the punitive” (Baker et. al., 2015; Morgan, Salomon, Plotkin, & Cohen, 2014). The ARTIC can be used both to monitor and resist such deterioration. For schools or organizations that have already implemented TIC, the ARTIC can be used to determine which personnel need additional training and supervision to practice in a more trauma-informed manner. In short, the ARTIC provides the first psychometrically reliable and valid tool to help researchers, practitioners, policymakers, and consumers assess TIC and its effects.

To learn more about the ARTIC Scale including how to obtain it, visit [www.traumaticstressinstitute.org](http://www.traumaticstressinstitute.org).

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**Courtney N. Baker, Ph.D.**, is an Assistant Professor in the Department of Psychology at Tulane University. Her career is committed to bridging the gap between research and practice, with a particular focus on facilitating the translation of evidence-based programs into under-resourced school and community settings. Dr. Baker's research is guided by the fields of dissemination and implementation research and prevention science, and it is distinguished by its interdisciplinary nature. She is the recipient of state and federal grants, including serving as co-PI on a National Institute of Justice-funded grant on trauma-informed schools.

## International Psychologists

Division 56 is seeking international psychologists to write articles for upcoming editions of *Trauma Psychology News*. Please contact Elizabeth Carll at [ecarll@optonline.net](mailto:ecarll@optonline.net) for more information or to submit an article.

## Two Women Making History: EMDR in the U.S. Air Force

By: Dawn M. Brock, PsyD, ABPP and Amy Roberts, PMHNP

This paper is written with the intent to present a snapshot about what treating trauma with Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1989) therapy in the military (Lipke, 1995) has been like for two commissioned U.S. Air Force (USAF) mental health providers. Dawn Brock is a licensed Clinical Psychologist, Major and Flight Commander for a Mental Health Clinic (MHC) at Altus Air Force Base (AFB), Oklahoma, and Amy Roberts is a licensed Psychiatric Nurse Practitioner, Captain, working at a large MHC at Wright Patterson AFB, Ohio. EMDR is one of three Veteran's Affairs/Department of Defense (VA/DoD) evidence based practices (EBT) for PTSD (2010); until October 2015, USAF providers did not receive training in EMDR. It is hoped that this article will shed light on the need for more EMDR therapists in the military, specifically the USAF.



*Dawn M. Brock, PsyD, ABPP*

The year is 2007, the military is heavily engaged in Operation Iraqi Freedom, all branches are deploying to the combat zone in frequent 6-month to 15-month cycles. The military operations tempo is high, but mental health problems are increasingly surfacing, fatigue is starting to set in for some, while the rate of deployment volunteerism is bafflingly high for others. Literature about working with the military and their families are abundant, particularly in relation to the stressors of deployment and the reintegration process following deployment. The high operations tempo often masked the impact of the deployed duties and experiences. For one of the first times in history, Airman, Seamen, and women were recognized for frontline, boots on the ground, war efforts. This same year, Dr. Brock was entering the USAF to complete an American Psychological Association Internship at Malcolm Grow Medical Center, at the then called Andrew's AFB, Maryland.

Prior to 2007, Dr. Brock worked with Police, Fire, and EMS in and around the states of Rhode Island, Massachusetts, and New Hampshire. Through ride-alongs and on-duty interactions, she spent years learning first-hand what stressors first responders experienced. In 2004, she learned how to treat their traumatic experiences with EMDR. EMDR was the treatment of choice in the spe-

cialty program she worked during that time, and from Dr. Brock's perspective, the clinical utility of EMDR was incredibly efficient and effective for First Responders. Dr. Brock found through the work of the other clinicians and her own services, that EMDR not only allowed the first responder clients to continue their careers, but allowed some of whom were referred to as "double hatters" to continue to deploy. That is, it is not uncommon for many first responders to also be members of the National Guard or Reserves. This specialty population is in large part why she chose a military internship. It was not a comfortable experience for her to treat "double hatters" without understanding the military culture or the deployed environment. Dr. Brock's internship and continued military experience provided her with a wonderful anthropological opportunity, while continuing to hone her trauma therapy skills. During her residency year, Dr. Brock and her peers were trained in both Prolonged Exposure (PE; Foa, Hembree, & Olasov Rothbaum, 2007) and Cognitive Processing Therapy (CPT; Resick, Monson,

& Chard, 2006); EMDR therapy was not permitted for use during the internship year. After implementing PE and CPT with various patients, Dr. Brock continued to prefer and be a proponent for EMDR therapy.

In the fall of 2008, Dr. Brock received her first assignment to Robins AFB, Georgia during which her supervision gave permission for all trained providers to use EMDR therapy. Dr. Brock was then fortunate to be relocated to two overseas locations and her current stateside assignment that have not only allowed EMDR therapy, but also provided her the opportunity to pursue becoming an EMDR International Association (EMDRIA) Certified Therapist and Approved Consultant. Dr. Brock's experience with EMDR therapy in the military environment was that it was a silent skill. Therefore, she had not considered pursuing becoming an EMDRIA Approved Consultant until a previous supervisor contacted her about being an EMDR Consultant for the Mental Health Clinic staff at Wright Patterson AFB; specifically, for a Psychiatric Nurse Practitioner, Captain Amy Roberts. It was at that moment that Dr. Brock was hopeful that the culture of trauma treatment in the USAF was changing, and she anticipated that this opportunity might promote EMDR around the USAF.

The opportunity to be trained in EMDR in 2012 seemed



like a natural progression in Captain Roberts' career. Following completion of the psychiatric nurse practitioner program at Fairfield University in Connecticut, she was preparing for transition to active duty service in the USAF. She first began putting training into practice during clinical rotations in the VA Healthcare System, where she was one of two providers using EMDR to treat PTSD. These experiences motivated Captain Roberts to bring EMDR to the military. It was both a surprise and a source of motivation when she arrived at Wright Patterson AFB and realized she was the only EMDR trained provider in one of the largest outpatient MHCs in the USAF. While most mental health providers there participated in annual DoD sponsored trainings for PE and CPT, EMDR therapy was not on the training radar. Similar to Dr. Brock, the use of EMDR in Captain Roberts' practice was sanctioned, but the silence around the absence of EMDR training for other military providers carried on without contest. She provided pharmacotherapy for service members, veterans, and adult beneficiaries suffering from a variety of mental health conditions, including many with PTSD seeking medication to manage their symptoms. Some had previously attempted PE or CPT, or both. Most patients had never heard of EMDR. It became clear to Captain Roberts that this was not due to patient preference. The clinical need for increased access to all of the EBTs for PTSD was evident. While mental health providers continued to refer military members to off-base intensive PTSD treatment programs, the sheer number, complexity, and potential lethality of PTSD in active duty MHCs continued to grow. This felt like an ethical dilemma sitting on a culture of status quo.

The inter-base relationship developing between Dr. Brock and Captain Roberts became a catalyst in their mutual efforts to bring EMDR to the active duty USAF population. The need for unrestricted access to all EBTs for PTSD, including EMDR seemed indisputable and incompatible with the empirical knowledge of its benefit. With guidance and support of Dr. Brock miles away at Altus AFB, Captain Roberts was driven to facilitate EMDR training at Wright Patterson. Her journey led to meeting Dr. EC Hurley, a retired Army Colonel with over 33 years of service in the US Army and EMDR training experience. Dr. Hurley agreed to provide the training, and Wright Patterson AFB leadership perceived this opportunity as not only a way to recapture referrals, but also a means to strengthen readiness and return more service members to duty. Finally, Captain Roberts' campaign for EMDR proved to be successful. In August 2015, Wright Patterson Medical Center MHC was granted funding for Dr. EC Hurley, an expert

in military trauma, to facilitate EMDR training for 24 mental health providers from three USAF MHCs; eight of these providers are interns who will take their skills to their first USAF assignment, stateside and abroad, later this year.

Dr. Brock and Captain Roberts have now worked together for 15 months. This is a pivotal, history-making moment in the EMDR therapy movement and for the USAF. As any EMDR therapist can appreciate, despite nearly 30 years of empirical support, EMDR therapy has remained widely unsupported and this discrimination of treatment must no longer be tolerated. It is important to recognize that even with training in PE, CPT and EMDR, many mental health providers offering services to military members will not desire to provide trauma treatment, and those who do will likely prefer one treatment/form of therapy over the others. It is a best practice to offer training and clinical support for all three. To discriminate against EMDR therapy is a disservice to the men and women suffering from the experiences endured while serving our country.



Amy Roberts, PMHNP

It is also the hope that EMDR therapists across all branches of military service keep this dialogue open and voice their experiences and recommendations, and understand its application beyond trauma; more specifically that EMDR has empirical support for treating other diagnostic presentations and comorbidities that also have significant career impacts for military members. Perhaps the EMDR training opportunity at Wright Patterson AFB will inspire more funding within the DoD to not only train providers, but also conduct research on the use of EMDR for active duty members and veterans. In the meantime, Dr. Brock and Captain Roberts are two women who share a sense of pride in knowing their combined efforts to challenge *what was* and inspire *what can be* laid groundwork for the future of treating military trauma in the USAF.

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**Dr. (Major) Dawn M. Brock** is a Clinical Psychologist, with an American Board of Professional Psychology specialty in Clinical Psychology. Dr. Brock is also a U.S. Air Force commissioned officer, currently stationed at Altus Air Force Base, Oklahoma. Dr. Brock serves as the 97th Medical Group's Mental Health Flight Commander, where she is responsible for 14 staff and five programs to promote the psychological health of 5,000 beneficiaries. She was raised in Joliet, Illinois and following the completion of her Clinical Psychology Doctoral Internship program at Joint Base Andrews in 2008, received her doctoral degree from Antioch University, New England.

**Captain Amy Roberts** serves as Psychiatric-Mental Health Nurse Practitioner, USAF, 88th Medical Group, Wright Patterson Air Force Base, OH where she provides full spectrum psychiatric care to service members, veterans, and adult beneficiaries. She graduated from University of Connecticut (BA) and Quinnipiac University (BSN). Roberts went on to complete her Master's degree in nursing at Fairfield University and received certification from the American Nurses Credentialing Center as a Family Psychiatric-Mental Health Nurse Practitioner in 2013. Roberts was born in 1983 in Milford, CT. She currently resides in Dayton, OH with her husband, Tim.

## Addressing Trauma in General Medical Health Settings

**Co-Chairs: Terri deRoos-Cassini, PhD & Ann Marie Warren, PhD**

**Task Force Goal:** To evaluate and create awareness of the role of psychologists to address trauma related issues in multiple medical settings.

**Summary:** The impact that trauma can have on health has been well established. However, the integration of psychologists into medical teams to address trauma related issues to improve overall health is still emerging. For example, there are only a few psychologists across the country who provide care to injured trauma survivors as integrated members of the medical team. The purpose of this task force is to evaluate the role of psychologists in multiple medical environments and to



Terri DeRoos-Cassini, PhD



Ann Marie Warren, PhD

develop job descriptions for these unique roles. This will likely involve developing connections between APA Division 56 and those professional organizations (i.e., American College of Surgeons) to discuss ways that psychologists could improve trauma focused care for specific populations of patients. The goals of this task force include: developing job descriptions that can be utilized by hospitals interested in developing roles for psychologists, connecting with national medical organizations to educate them about the role psychologists can serve, and develop connections between psychologists in these unique and evolving positions. If you are involved in your medical center in a role specific to addressing the impact of trauma, please email us at [tcassini@mcw.edu](mailto:tcassini@mcw.edu).

## Meeting the Needs of Veterans in the Community

**Co-Chairs: Sonya Norman, PhD and Jessica Hamblen, PhD**

The idea for this new task force emerged from discussions with our president, Dr. Joan Cook, about what Division 56 can do to help prepare psychologists who are treating veterans with trauma related disorders in the community. There are approximately 22 million veterans in the U.S. and more than 3.7 million have trauma-related mental health problems

such as PTSD. It is clear that a large number of veterans prefer to receive their healthcare outside of the VA. Recent studies suggest that as many as 30-56% prefer to receive care outside of the VA, with even higher rates among female veterans. These statistics suggest that many psychologists in private practice and in community based treatment settings are likely to encounter veterans

in their practices. Yet, studies that have queried mental health providers show that a large number have questions or need more information about military culture, evidence based treatments for trauma related disorders, or resources to help them effectively treating veterans.

The goal of Division 56's new Meeting the Needs of Veterans in Community Settings task force is to help provide mental health professionals with the resources they need to effectively treat veterans who come to them for care. We are currently in the



*Sonya Norman, PhD*



*Jessica Hamblen, PhD*

process of finalizing our goals for the task force. These will include: (1) Querying psychologists about information and resources they feel they need to help them treat veterans, (2) Identifying specific knowledge, skills, and abilities recommended for effectively treating veterans in the community, and (3) Developing a comprehensive list of resources for psychologists treating veterans, including on-line trainings, educational materials, written and web-based materials to share with Veterans and their family members, and consultative resources.

## Developing Web-Based Trauma Psychology Resources

**Co-Chairs: Amy Ellis, PhD and Vanessa Simiola, MA**

The purpose of this task force is to carry out the recently awarded Committee on Division/ APA Relations (CODAPAR) grant entitled, "Developing Web-Based Trauma Psychology Resources On Underserved Health Priority Populations for Public and Professional Education." Presently, there are high rates of trauma and associated negative mental health consequences in underserved populations and a dearth of widely disseminated literature addressing their unique concerns.

The purpose of this grant is to create web-based empirically-informed materials (i.e., printable fact sheets, YouTube videos, and suggested reading lists) on trauma and its impact in underserved health priority popula-

tions that will serve as valuable resources for clinicians, researchers and the public. Division 56 will serve as the hub for the collaborative teams from Divisions 12 Section II (Clinical Geropsychology), 20 (Adult Development & Aging), 27 (Community Research and Action: Division of Community Psychology), 33 (Intellectual & Developmental Disabilities), 44 (Lesbian, Gay, Bisexual, and Transgender Issues), 45 (Culture, Ethnicity & Race), and 53 (Clinical Child and Adolescent) to create an ideal combination of experts. The Division 56 website will serve as the main repository of all collaborative information, with other participating Divisions offering to host information as well. This project is designed to meet APA's goal of educating professionals and the public about psychology's role in health and well-being.

### Division 56 Listservs

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

**div56@lists.apa.org**  
**div56childtrauma@lists.apa.org**  
**div56dissociation@lists.apa.org**  
**div56ecpn@lists.apa.org**  
**div56stu@lists.apa.org**

*for discussion among members*  
*for child trauma topics*  
*for post-traumatic dissociative mechanisms development*  
*for early career psychologists networking*  
*for student forum*



# International Committee Update

By: Elizabeth Carll, PhD

With the largest number of refugees seeking safety since World War II, the International Committee is presenting a symposium at the 2016 APA Convention in Denver, Colorado to address this global problem. The symposium on the refugee crisis was organized by Elizabeth Carll and Carl Auerbach. It addresses the various roles of psychologists and lessons learned when working with refugees from various parts of the world including Syria, Africa, China, North and South America. Symposium participants include Carl Auerbach, Greg Lewis, Adeyinka Akinsulure-Smith, Cynthia de las Fuentes, Barbara Streets, William Salton, and Elizabeth Carll.



Elizabeth Carll, PhD

*The International Committee Interview Series With International Trauma Psychologists* is conducted by student

members with trauma psychologists from various parts of the world. The current interview, which follows, was conducted by doctoral student member, Christopher DeCou, with Dr. Marzia Giua, who resides in Rome, Italy. Dr. Giua describes her clinical and forensic experiences providing a range of trauma services.

To encourage participation of international students at the APA convention, the Division provides an annual \$500 student stipend and complimentary convention registration to support travel from a developing country, who has a trauma related poster, paper, or presentation accepted for the convention. A free one year membership in Division 56 is also included. Interested candidates for the travel stipend should contact: Dr. Elizabeth Carll,

Chair, Division 56 International Committee, at [ecarll@optonline.net](mailto:ecarll@optonline.net)

## International Committee Interview Series: Dr. Marzia Giua

By: Christopher R. DeCou

Dr. Marzia Giua is a clinical psychologist in Rome, Italy who has served as a trauma psychologist in a variety of settings, including clinical and forensic contexts. She is a technical consultant to the Public Prosecutor of Rome concerning the psychological treatment needs of justice-involved minors. She has also served in several organizations committed to addressing the needs of survivors of human-trafficking, partner violence, child abuse, and sexual exploitation. She is the coordinator of a Center of Psychological Support for victims of child abuse, human trafficking of minors, and gender violence.

She is also involved with several other European agencies, including Schiavitù Mai Più ("Slavery No More") and My Choice, which work to abolish and prevent human-trafficking. Dr. Giua is a member of the Italian Order of Psychologists (Latium) Work Group focusing on partner violence.

During our interview Dr. Giua shared how her training experiences led to her longstanding commitment to the

treatment of trauma survivors and the prevention of human-trafficking across diverse settings.

Dr. Giua completed her graduate coursework at Libera Università Maria SS Assunta (LUMSA) in Rome in December 2004. She has been licensed as a Psychologist by the National Council of Order of Psychologists since 2006. She shared that her early experiences as a psychology student included coursework addressing the complex factors that lead to childhood victimization. These factors included understanding the intersection of criminal law involving perpetrators' mental health and the needs of survivors of sexual violence, particularly children. This exposure to the difficult and complex underpinnings of sexual victimization was consistent with her goal of being "directly involved" in addressing survivors' mental health needs.

Following her graduation, Dr. Giua completed post-graduate training in systemic relational psychology at IEFCoS: Scuola di specializzazione in psicoterapia Sistemico-Relazionale ("Postgraduate School in Systemic Relational Psychology") in Rome in 2012. Dr. Giua described systemic relational psychotherapy as a form of

integrative psychotherapy, which requires the synthesis of multiple approaches, including interpersonal, cognitive-behavioral, and psychodynamic techniques. In addition, this approach considers symptoms and functioning across individual, family, and community contexts. Dr. Giua noted how this integrative approach is well suited to work with trauma survivors, who often present complex symptoms of distress. She has worked extensively with survivors and perpetrators of childhood sexual abuse and partner violence.

As a forensic expert (Court Consultant appointed by the Public Prosecutor), Dr. Giua is responsible for assisting with the assessment of treatment needs and psychological well-being of children and adolescents who are taken into police custody in connection with human-trafficking and sexual exploitation investigations. She supports the survivors who become involved in the legal system, but could also be involved in an additional work for the Prosecutor's office and the court system.

Dr. Giua explained how the process of balancing these distinct, yet related, interests included ongoing collaboration with other professionals, including judges, social workers, and other healthcare providers. Indeed, interdisciplinary collaboration has been a large focus of Dr. Giua's work with survivors of diverse forms of trauma and victimization, including her involvement to inform policy and procedures with professional associations and other non-governmental agencies that are involved in preventing human-trafficking.

Dr. Giua has worked with survivors of various forms of trauma. She shared about one case where she was asked to assess a child from Central Africa who was believed to be a survivor of human-trafficking. Through collaboration with local authorities and an interpreter she was able to help establish the child's status as a survivor of human-trafficking, and informed the court as to the developmental and psychological issues involved in cases of child trafficking. In another case, Dr. Giua assisted an adolescent from outside the European Union, who survived maltreatment and witnessed violence, and subsequently utilized a helpline to contact the authorities for assistance.

In these and other cases, Dr. Giua shared how she focuses on avoiding secondary traumatization, and seeks to

build an empathic and effective relationship with justice-referred youth. Dr. Giua also identified the importance of effectively synthesizing verbal and non-verbal communication, particularly within the assessment of trauma-exposed youth in forensic contexts.

Dr. Giua described how international collaboration is key to addressing the challenges facing survivors of human-trafficking, violence against women, and the needs of refugees. She explained how survivors of human-trafficking and refugees fleeing violence are often displaced across national and cultural contexts in ways that complicate and hinder effective psychological treatment and coordination of services.

Collaboration among international professionals may allow for culturally-resonant policies and intervention strategies that emerge from the diverse cultural and national perspectives of the professionals involved. Dr. Giua noted the efforts of the American Psychological Association and Division 56 as examples of how efforts to connect psychologists across the globe enable "fruitful cooperation," which may yield trauma-informed policy and intervention for survivors of human-trafficking and other forms of victimization.

Dr. Giua offered some general advice for students and early career professionals wishing to pursue careers in trauma and forensic psychology. First, Dr. Giua stressed the importance of mentorship throughout all stages of professional development, and noted the important support provided by her own mentors. Second, Dr. Giua noted the need for strong inter-professional relationships, including collaboration during graduate training. Finally, Dr. Giua emphasized how psychologists can and should integrate their own commitment to social justice, and "service above self" within clinical, and policy initiatives.



*Dr. Marzia Giua*



*Christopher R. DeCou*

***Christopher R. DeCou, MS, is a Doctoral Candidate in the Clinical Psychology program at Idaho State University in Pocatello, Idaho. He is the current Division 56 Student Representative and a student member of the Division 56 International Committee. His research interests center on the study and prevention of suicide, including suicide prevention among under-studied and under-served populations, and the association between trauma exposure and suicidality.***

# Clinical Competence in Treating Traumatic Stress: Considerations for Early Career Psychologists

By: Divya Kannan, PhD

The prevalence of traumatic stress has grown rapidly in recent years (Kilpatrick et al., 2013), requiring mental health professionals to review standard practices for treating this sequelae, as well as augment their training to provide trauma-specific treatment (Kannan, 2015). Several patient-related stressors have accounted for the rise in acuity in traumatic stress over time, including vulnerability to risk factors (e.g., repeated exposure to trauma, substance use), willingness to seek professional help, and improved access to psychiatric care which allows more individuals with serious mental health concerns to function within highly demanding academic and work environments (Gallagher, 2014). As a result, psychologists are treating patients who present with greater levels of stress as well as high acuity, a combination that calls for a more deliberate approach to trauma-focused treatment. As an early career psychologist working within a university counseling and medical center, I have found that the psychological care of my patients has grown into a broader, trauma informed system due to this trend of rising acuity and complexity in presentations of traumatic stress. In this paper, I share some of the considerations involved in developing a clinically-focused career in the field of traumatic stress based on my experience and training.



Divya Kannan, PhD

## A Trauma-Informed Model of Care

The American Psychological Association (APA) defines evidence-based practice as “the integration of the best available research with clinical expertise in the content of patient characteristics, culture, and preferences” (APA, 2006, p. 273). While not all clinicians have extensive trauma-focused training, the emergent clinical needs among individuals coping with traumatic stress has resulted in an increased need for developing trauma-specific, evidence-based practice. Unfortunately, a focused study of trauma has not

been an integral component of doctoral level training in psychology (Courtois & Gold, 2009; DePrince & Newman, 2011; Gold, 2014), leaving the impetus on practicing psychologists to develop programs and create opportunities within their systems of care that lead to improved outcomes in treating traumatic stress (Cook & Newman, 2014). Recommendations for entry level practice and early career psychologists are based on the expert consensus guidelines laid out by the International Society for Traumatic Stress Studies (Cloitre et al., 2011) and the New Haven Competencies for Training and Education (Cook & Newman, 2014), which are broad enough to be applied to a variety of clinical settings.

## Team Your Way Through

Collaborating and working with a treatment team can shape and expand your clinical formulation and understanding of traumatic stress. Particularly when working with complex trauma, doing this work in isolation is an added challenge due to the immersive nature of therapy that requires therapists to empathically

relate to patients who share trauma narratives that are likely to be quite detailed and painful to engage. Additionally, treating individuals with complex trauma histories can be overwhelming to clinicians due to the multiple areas of dysregulation that needs to be addressed. Shared decision making has been identified as an important competency among practitioners in managing the complexity of a trauma-focused practice, regardless of the setting in which you work (Cook & Newman, 2014). Team approaches can also help clinicians manage the effects of secondary traumatic stress (STS), where vicarious or secondary exposure to trauma can lead to negative outcomes for providers and be a potential barrier to effective care, if not addressed (Cieslak et al. 2013).

An example of this approach might include creating forums for addressing the complexities of trauma-based practice via case conference/discussion meetings. The goal of these meetings could be to work towards collective competencies through interdisciplinary collaboration, such as arriving at a consensus for benchmarks around trauma-informed assessment, diagnostic considerations, and treatment planning, while also addressing the impact on providers.

*Acknowledgements:* Dr. Cathy Fuchs, MD, Director, Vanderbilt Psychological & Counseling Center, Vanderbilt PCC Trauma Team & Acute Care Team



## Think Systems and Layers

Psychological and behavioral health services are routinely integrated into larger health and primary care settings, and psychologists are also expanding their consultative roles within these settings (James & Folen, 2005). This diversification is largely a result of the recognition of psychology as a crucial component of the biopsychosocial model of health and wellness. Therefore, establishing best practices for trauma-informed care needs to be implemented within the existing institutional framework, as treatment decisions will be impacted by various structural factors (e.g., policies, availability of resources, systems of communication, institutional norms).

One idea of working systemically is the development of a liaison system where clinicians can reach out to other providers and departments to help create a line of communication across disciplines (via a formal procedure or more informal/need-based). This coordination of services and communication can be an important skill to develop as exposure to traumatic events might affect patients in different ways (e.g., academic functioning, disability status, legal reporting of assault). More generally, behavioral intervention teams (e.g. engaging police, mental health providers, administrative staff, and other system partners) also serve a similar purpose (Douce & Keeling, 2014), where psychologists utilize consultative roles to educate non-mental health providers who may make decisions regarding the welfare of those impacted by psychiatric concerns. This is consistent with competencies outlined to work collaboratively across systems to improve mental health outcomes (Cook & Newman, 2014).

## Contextualize your Practice

Developing an understanding of contextual factors can guide professional development by using trauma-focused knowledge, skills, and training to connect to the unique needs of the population with which you work. Specifically, this refers to the social context such as family interactions, peer relationships, and the larger community within which the individual has experienced a traumatic event. Clinical decisions and treatment planning should be responsive to these factors and should be guided by the literature on how interpersonal trauma impacts biological, cognitive, social, and emotional development. For instance, the variability across patients in being able to tolerate exposure-based therapies can be a combination of their biological sensitivity to stress, individual cognitive-emotional responses, as well as environmental responses after the traumatic event occurred, coping flexibility, and access to support systems. In order to provide intervention to meet the variability around sensitivity to exposure therapies, adjunct approaches to care can be considered that enhance skill building and increase

engagement in therapy (e.g., biofeedback training, DBT skills training, seeking safety groups). Another example of being responsive to contextual factors within a university mental health center, could be recognizing the need to support students in an acute phase after an assault or other traumatic event while they may not typically have access to their usual support systems or may feel ambivalent about disclosing trauma to family members or friends. Providing students with multiple points of access to programs or services on campus that offer a time-sensitive response can help restore their sense of safety from physical harm and reduce risk of re-traumatization, as well as provide education about adaptive psychological responses after a traumatic event (Fallot, 2008).

## Diversify your Knowledge Base

Diversity within trauma-informed training includes, but is not limited to conceptual issues, empirical models, applied interventions, and policy-oriented issues related to trauma (Layne et al., 2014; Mattar, 2011). Consideration of how diverse types of trauma exposure impact treatment (e.g., interpersonal violence, disaster, military), as well as addressing the impact of cultural, racial, gender, sexual identity, and ability/disability status of patients aids clinicians in understanding the social, historical, and intergenerational context of trauma-related experience. Cook et al. (2011) reported on findings from a survey conducted by the American Psychological Association Practice Organization, which assessed practicing psychologists' interest in additional clinical training on trauma-related issues and topics. Over 60% of survey respondents expressed interest in participating in additional training to learn more about trauma-related clinical topics, speaking to the gap between education around trauma and need for learning. Any best practices as it relates to trauma should be situated within a framework of ongoing education about clinical research and practice. Learning about multiple evidence-based models of care (e.g., community based, integrative, biological), dissemination of trauma-based competencies with trainees, initiating dialogue with local psychology or counseling training programs in your area, joining organization listservs (e.g., APA, ISTSS), and attending annual meetings are some of the ways in which you can evaluate, refresh, and update your understanding of trauma-specific issues. This is also an opportunity to have access to and receive feedback from the larger psychology community. Additional forums to promote knowledge sharing such as creating or joining a journal club, seeking opportunities for professional mentorship, attending local psychology practice associations, or sharing web-based trainings and seminars with your colleagues can demonstrate a commitment to critically review published literature and integrate general competencies and clinical skills with trauma-specific knowledge (Cook & Newman, 2014).

## Conclusion

Providing trauma-informed care can be best understood as a developmental process of learning and this has been true of my training and experience. Early career psychologists are well positioned to be innovative in their career trajectories and expand their role beyond traditional psychologist roles. Staying updated on trauma-related knowledge and experience through teaching, research, development of new ideas and programs, taking advantage of system resources, and seeking mentorship where possible can continue to help you shape your identity and advance the field of traumatic stress.

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**Divya Kannan, PhD**, is an assistant professor of clinical psychiatry at the Vanderbilt University Medical Center. She leads the trauma team at the Vanderbilt Psychological & Counseling Center and has a primary clinical interest in working with complex trauma and sexual assault. She has expertise in using qualitative methods of inquiry and has focused her research interests on the investigation of factors that impact the process and outcome of psychotherapy.

## Social Media News

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

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# Latina Voices, Walking the Journey with Our *Hermanas*

By: Janice E. Castro, B.A. & Danielle Quintero, M.A.

More than one in three women in the United States experience intimate partner violence (IPV) at some point in their lives (Centers for Disease Control [CDC], 2011). There is a correlation between the consequences of IPV and depressive symptoms, posttraumatic stress disorder (PTSD), and suicidal ideation (Pico-Alfonso et al., 2006; Yuan, Koss, & Stone, 2006). Throughout our personal and professional lives, working with survivors of sexual violence (SV)/IPV has been one of the most rewarding experiences. However, considering the impact on clinicians working with survivors of IPV, as advocates, we are aware of our vulnerability to various stressors that could lead to burnout. By sharing our personal knowledge, we seek to provide validation for other students who may have similar experiences. This paper demonstrates the importance of integrating self-care practice among those who have the privilege of working with the strong *mujeres* (women) recovering and healing from trauma.

As mental health providers, we are highly vulnerable to various stressors that could lead to burnout, which is described as an experience that consists of three dimensions: (a) emotional exhaustion, (b) depersonalization, and (c) reduced personal accomplishment when working with clients (Maslach, Schaufeli, & Leiter, 2001). Some of the consequences of burnout are diminished work productivity and effectiveness, absenteeism, and substance use (Maslach, et al., 2001). It is evident that symptoms of burnout may arise when working with SV/IPV survivors, but sometimes we wait until things are strenuous to consider and engage in self-care.

A recommended self-care strategy begins with clinicians normalizing and validating their own experience by giving voice to their thoughts and feelings (Knight, 2013). In our own experiences working with female SV/IPV survivors, we witnessed the strength and resilience

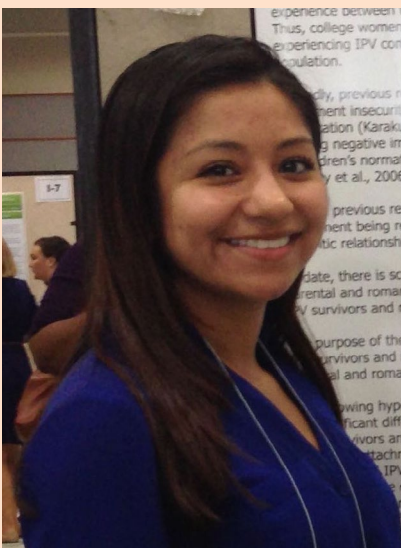
that many of these women bring into the therapeutic relationship and how they have flourished since the time of the event. In the same breath, we acknowledge these women's traumatic experiences were often difficult to cope with and frequently impacted their healing process, because telling their stories could lead them to revisit

emotional pain. A need for self-care is particularly important for doctoral students working with trauma survivors as early-experienced clinicians are at a higher risk for burnout (Craig & Sprang, 2010).

For us, working with these women was particularly impactful because we could empathize with them on a personal and professional level. As Latinas ourselves, we were both able to connect on a humanistic level and as *mujeres*. The intersectionality of our shared cultures facilitated a natural connection, as the similarities in our identities and experiences helped us to better understand each other. When working with Latinas, we felt extremely connected to our *hermanas* (sisters), due to our shared cultural background, as their stories were similar to those from our own communities. As Latinas/os in the U.S., we have a shared history of painful experiences related to collective and structural trauma, such as being oppressed and colonized, racism, and discrimination (Arredondo, Gallardo-Cooper, Delgado-Romero, & Zapata, 2014). From one Latina to another, we related to the cultural context in which their stories took place and understood many of the political, social, environmental, and cultural struggles they disclosed, but also recognize the cultural diversity within our Latina/o community.

We were privileged to offer support and care to trauma survivors, but also not immune to the possible experiences of

burnout. At times we felt overwhelmed, upset and defeated that issues of violence continued to affect many *mujeres* in our community. Being in session with another *mujer* has contributed to the therapeutic relationship because of our shared cultural experiences, which allowed us to identify with our *hermanas* from personal experience in terms of language, customs, immigration,



Janice E. Castro, BA



Danielle Quintero, MA



acculturation, and oppression. This shared culture also identified various personal triggers, such as the different levels of acculturation among family members and the English language as a barrier for resources and opportunities. It was during these times that we began to realize in order to continue treating our *hermanas*, we needed to practice self-care so we could continue walking with them through their therapeutic journey.

### Self-Care

These stories are consistent and common experiences we have encountered while working with Latina trauma survivors. We realized that it was not only our duty to care for the *mujeres* with whom we worked, but also care for ourselves. Our self-care strategies consist of praying, exercising, and grounding ourselves in activities that simultaneously replenish our mind, body and spirit and allow us to stay connected to our cultural roots. Another self-care strategy we use is to connect ourselves with the Latina/o community outside of an academic institution through volunteering. During clinical work and personal time we use mindfulness, a nonjudgmental experience of moment-to-moment awareness of one's own bodily sensations, emotions, and activities (Dunn, Callahan, & Swift, 2013). Research demonstrates that practicing mindfulness and increasing one's self-awareness can serve as self-care to combat burnout among mental health counselors (Thompson, Amatea, & Thompson, 2014). We strongly believe that these activities allow us to preserve our overall wellbeing while also nurturing our souls. Self-compassion and self-care also benefit us and allow us to continue our own journey of the systemic oppression that Latinas often face.

As mental health professionals who work in the trenches of trauma, we attempt to practice self-care not only for ourselves, but also for the women with whom we work. In graduate school, self-care is emphasized, but through trial and error we consistently reconsider when to pull back from certain activities to balance responsibilities. However, we strive to include self-care in our lives because we emphasize this need in our work with clients. We've learned to value our own experience while honoring the experiences of other Latina trauma survivors. A quote illustrated by Audre Lorde sums this up best: "Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare."

### First Narrative (Janice)

I reached a moment where I experienced depersonalization (cynicism), understood as feeling emotionally distant from one's client (Maslach et al., 2001). While sitting in session listening to a *hermana's* traumatic narrative, I thought, "what if this story was a lie?" I surprised myself and questioned: "why would she lie?" then reoriented myself to the present moment. It was difficult listening to one client after another tell me their personal traumatic experiences throughout the day, but I did

not want to cancel appointments with my *hermanas* that day knowing I had the time.

Their stories can be hard to hear because of the social injustices happening within my community and across the country. Yet, it is incredible to find how resilient these *mujeres* are when experiencing individual SV/IPV, as well as collective, and structural trauma. For example, I had a *hermana* experience multiple types of abuse including sexual assault and victim blaming by her employer, as well as mistreatment due to documentation status and limited proficiency in the English language. These intersecting issues of systemic oppression hindered her healing processing and impacted me as a Latina advocate, who has experienced similar forms of systemic oppression. Hence, I developed a strong connectedness with my *hermana* because we share similar cultural values and similar abuse was prevalent in my family. To help my *hermana*, I was eager to provide community resources and grounding techniques for self-care that I use myself during overwhelming moments.

### Second Narrative (Danielle)

One particular moment that resonates deep within my heart occurred during my previous work experience as a community rape crisis center counselor. While I was confident that the training I received had sufficiently prepared me to take on any task that may arise, it was not until my first medical accompaniment with a Latina survivor in which I became fully aware of the emotional and psychological effects that rape has on an individual, her/his surrounding environment, community, and loved ones. Upon my arrival, the young *mujer* who was assaulted was alone and in a state of crisis. As I sat beside her, I proceeded to provide her with crisis counseling, done without the protocol guide sheet in front of me, but rather spoke organically in English and Spanish to better foster communication through our shared language. I identified that she and I had a natural connection which stemmed from our similar cultural backgrounds and upbringings as Latinas who continuously combated against community violence.

We began the medical exam that would ultimately gather physical evidence of the assault for legal trial purposes. While on the medical table, she asked me for a different type of support. My *hermana* asked me, "Can you hold my hand, please?" I held her hand throughout the entire process, and felt every muscle reaction through her palm as she twitched with pain. I didn't let go, and felt more of an urge to hold on longer as she periodically squeezed my hand tighter when she felt small bursts of pain from the medical tools being used. I helped guide her through the entire process, and after the exam, proceeded with additional counseling and shared with her the services that were available to her. However, upon departing, I was plagued by the thought of what would happen next and became concerned for her healing, coping mechanisms, and well-being thereafter. I was afraid

and feared for the wellbeing of my hermana. This experience proved emotionally taxing as I continued my advocacy work at this agency.

### Conclusion

From our experiences, working with these mujeres requires more than just an understanding of their trauma, but also an understanding of the unique impact cultural factors have on healing and coping. Overall, women of all backgrounds demonstrate significant strength when experiencing trauma related to SV/IPV; however, when working with mujeres we also acknowledge significant cultural considerations because of the diversity within the Latina/o community.

A specific suggestion for ways that mental health providers could approach Latina SV/IPV survivors is taking a trauma-informed approach. With this method, at the organizational level, all components of an organization and their practitioners incorporate a thorough understanding of the prevalence and impact of trauma, the role that trauma plays, and the complex and varied paths in which people recover and heal from trauma (SAMHSA, 2014). Importantly, this definition includes a broad understanding of trauma including issues that may impact culturally-specific communities. For example, Bienestar (wellbeing) is a gender-specific and culturally based trauma therapy for Latinas that takes a holistic approach promoting physical, mental, and spiritual wellbeing (Comas-Diaz, 2015). Despite the difficulties and uncertainties of crisis intervention for SV/IPV survivors, having the privilege to hear our client's stories, being able to provide empathy, unconditional positive regard, and watch them connect with their internal strengths is what invigorates our passion to continue working with and for Latina trauma survivors as well as other women of color who may have similar experiences.

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**Janice Elena Castro, B.A.**, is a doctoral student in the Counseling Psychology program at the University of Nebraska-Lincoln. Her research and clinical interests are in intimate partner violence and higher education among the Latina/o community.

**Danielle** is a PhD candidate in Counseling Psychology at the University of Missouri. Her clinical interests include working with clients who have experienced trauma and Posttraumatic Stress Disorder (PTSD) as well as conducting psychological evaluations. Her current research focuses on sexual violence, coping, and resiliency among ethnic minority women, specifically Latinas.

## Invitation to Division 56 Fellows

Division 56 lists the names of all of our Fellows on our website. You can see the complete list by clicking on the following link: <http://www.apatraumadivision.org/85/awards-honors.html#fellows>. We are hoping to link more of our Fellows' professional websites to highlight the amazing work you are all doing. As you will see, some of our Fellows have already provided links. If you would like to link your website to the Division 56 page, could you please send the link directly to Tyson Bailey at [TDBaileyPsyD@gmail.com](mailto:TDBaileyPsyD@gmail.com).

# Review of *Treating Complex Stress Disorders: An Evidence-Based Guide*

Courtois, C. A., & Ford, J. D. (Eds.). (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. New York, NY: Guilford Press (488 pages) ISBN-13: 978-1462513390 ISBN-10: 1462513395 (\$38.00 hardback).

By: Annmarie Wacha-Montes, PsyD

**T***reating Complex Traumatic Stress Disorders: An Evidence-Based Guide* edited by Christine Courtois, PhD and Julian Ford PhD consists of 20 chapters written by experts in the field of trauma. The book provides a thorough review of empirical research, assessment measures, and treatment approaches for adults, adolescents, and children with complex traumatic stress. The content is presented in a user-friendly format that could serve as a resource for researchers, professionals, and trainees. Although the Diagnostic and Statistical Manual- 5 (DSM-5) did not incorporate complex traumatic stress disorder into the current edition, and the diagnostic criteria for posttraumatic stress disorder (PTSD) has changed, *Treating Complex Traumatic Stress Disorders: An Evidence Based Guide* still offers a wealth of information that can inform clinical practice and research.

The 33 authors, including the editors, aim to provide a thorough review of evidence-based literature offering guidelines for conceptualization, assessment, and treatment focused on complex traumatic stress disorder. In addition, the book provides information on many comorbid symptoms and presentations, such as difficulty with emotional regulation, relationships, dissociation, and identity, as well as other critical issues discussed in the field. The 466 pages allow for a wide selection of tools and approaches tailored to the needs of this population and those working within the area of trauma.

The book is divided into three fundamental sections. The initial and most extensive section provides a comprehensive overview, clinical implications of related neurological and developmental research, and best practices in psychotherapy for complex traumatic stress disorders. It also includes a helpful chapter on assessment that identifies a number of self-report and interview measures used for children and adults alongside recommendations for their use. The final chapter of this section is a review of evidenced-based measures of attachment

style and abuse, including case illustrations of PTSD and complex PTSD, which provide useful depictions of the clinical implication on treatment. This section also incorporates research and discussion on relevant issues such as dissociation, cultural competence, therapeutic alliance, risk management, vicarious traumatization, and self-care. These chapters offer valuable resources that can be readily accessible for clinicians that include “tools” to assist with challenging scenarios and risk management (e.g., documentation, process comments, treatment duration and termination), and strategies to strengthen the therapeutic relationship and reduce burn out.



Annmarie Wacha-Montes, PsyD

After providing a solid foundation for understanding complex trauma, the editors dedicate the following section to individual treatments. Treatments include contextual therapy, cognitive behavioral therapy, contextual behavior trauma therapy, experiential and emotional-focused therapy, sensorimotor psychotherapy, and pharmacotherapy. The authors of the chapters skillfully describe the theoretical conceptualization, model of treatment, and summary of evidence. Each section concludes with a valuable case example and sample therapist-client transcript that demonstrates the theory and concepts, which enriches the reader's ability to understand the treatment.

The final section addresses systematic treatment modalities that include internal family systems therapy, couples, family systems, and group therapy. The authors of these chapters include the theoretical conceptualization and model, research, and a therapist-client transcript that makes these chapters a useful and innovative resource.

All sections are well written and contribute key points and summaries that highlight important information to consider during assessment and psychotherapy. The book emphasizes multiple factors that may impact the severity and chronicity of complex traumatic stress disorder reactions to trauma that can be used as a reference and resource. Although the editors acknowledge the wealth of empirical evidence on complex traumatic stress, the book does not offer comprehensive details.

At the conclusion of the book, the reader will become more familiar with a practical framework when working with individuals with complex traumatic stress disorders. The book is highly recommended for researchers



and clinicians to increase knowledge, as well as sharpen clinical skills. Moreover, the book could be informative for others who work directly with trauma survivors.

**Annmarie Wacha-Montes, Psy.D.** is a clinical psychologist and assistant director for community based services at Rutgers University Counseling, Alcohol and

other Drug Assistant Program and Psychiatric Services. She completed her postdoctoral fellowship at McLean Hospital/Harvard Medical School and internship at the Syracuse VA. Her training and interests include: trauma and co-occurring disorders, suicide prevention, crisis intervention, eating issues, guided self-help, and health psychology.

## Who's Who: Tyson Bailey, PsyD

### What is your current occupation?

I am currently a partner in Spectrum Psychological Associates, a group practice in Lynnwood, Washington. My clinical practice consists primarily of individuals who have a history of complex trauma. I also do forensic evaluations and teach seminars on Dialectical Behavior Therapy, suicide assessment, and trauma. In addition, I'm currently the practice representative for APA's Committee on Early Career Psychologist (CECP), as well as the website and associate newsletter editor for Division 56.

### Where were you educated?

I received my BS in psychology from the University of Washington, and my MA and PsyD in clinical psychology at Argosy University, Seattle. My internship was at the Fremont Community Therapy Project (FCTP) in Seattle, Washington, which was run by Laura Brown. We specialized in treatment posttraumatic reactions, including dissociation and other complex presentations. After graduating, I continued my postdoctoral training at FCTP, focusing primarily on increasing my knowledge of trauma treatment and forensic psychological assessment. I also served as the Dialectical Behavior Therapy (DBT) skills group supervisor for two years.

### Why did you choose this field?

I entered my undergraduate program to be an orthodontist. During my second year I had a sudden realization that I did not want to dig around in people's mouths for the rest of my life and had a short crisis moment as I realized I had no idea what I actually wanted to when I grew up. I happened to be in a sociology class at this moment, and approximately 24

hours later during the same course we talked about psychology. Something clicked, my body felt settled in a way that is hard to describe, and the decision was made. Although I used to say that psychology chose me, it was only later that I realized how much my training and teaching in the martial arts really served as the primer for what would later become my career.

My venture into trauma psychology was catalyzed by my teacher, mentor, and dear friend, Laura Brown. Her gentle yet firm guidance helped me to bring an authenticity to my life that is the cornerstone of the connected relationship needed for trauma work. While I entered into the field with the desire to work with trauma survivors, it was training under Laura and with all the amazing folks at the Fremont Community Therapy Project that opened my eyes to the field of trauma psychology.

### What is most rewarding about this work for you?

Creating deep, meaningful connections with people who previously believed humans were only capable of causing terror, distress, and suffering. While

this relationship is often viewed the fear at first, it is incredibly rewarding to watch people increase their willingness to be present and open within the therapy room. As I think about several of my clients who I have worked with since graduate school, the connection we have fills my heart and spirit during some of the more challenging moments, or the days where I wonder what it would have been like to actually be an orthodontist.

### What is most frustrating about your work?

I have worked with an unfortunate number of people who have had therapists who crossed ethical lines and caused even more difficulties in the lives of their clients.



*Tyson Bailey, PsyD*

Instead of the help they hoped to receive, these clients experienced betrayal of their confidence and trust in the very place they were told would provide healing and safety. In reality, this goes beyond a frustration, as it is inconceivable to me that anyone in a helping profession would abuse their power and privilege.

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

There is no way I could be where I am and doing all that I am doing without the support of my wife and the joy that our son brings. Spending time as a family, regardless of the activity, is one of the most critical aspects of my self-care. In addition, I have a number of close friends and colleagues who help prop me up during the more difficult times. I feel blessed to have such wonderful humans in my life, particularly after difficult days at the office.

I have also been training in the martial arts for almost 19 years, which has always provided me a sense of grounding and well-being. In addition to my own training, I have been an instructor for 16 years, which although was unknown to me in the beginning, was my first exposure to being a helping professional and eventually led to my dissertation. Although I do not spend nearly enough time behind the camera, I also enjoy taking pictures and have several of my prints hung in my office.

**What are your future plans?**

Continue to grow as a human being in every way possible, with a particular focus on increasing my skills as a parent and partner. Professionally, I hope to write, teach, and supervise on a more frequent basis. Finally, I would like to get more time in behind the camera, as it is one of the easiest places for me to remain focused on the beauty of the present moment.

## Lorraine Williams Greene, PhD, ABPP

### May 18, 1950 to February 25, 2016

Born in Elizabeth, New Jersey to Grace Watson Williams Lowery and Vasico Delin Williams, Lorraine Williams grew up listening to her grandmother offer help in problem solving with neighbors and strangers who came to her door in the evenings and on the weekends. Raised in a family of civil rights advocates, she learned the fine points of advocacy and principled negotiation from her family connections. As a young teenager she attended the 1963 March on Washington with family and church elders where she was imbued with a sense of service to others and social justice.

After high school she attended college at the University of Detroit and joined the Delta Sigma Theta sorority, a national service organization with which she would stay actively involved as a leader for the rest of her life. She graduated with majors in psychology and social work and then moved to Atlanta to work as a school psychologist for the Atlanta Public Schools. During this time, she earned her Masters in Educational Psychology at Atlanta University and simultaneously completed her School Psychology Certification at the University of Georgia at Athens.

She dreamed of developing a community mental health center and knew that to do so she would have to pursue the doctoral degree. Even though she had married Henry Greene she would not be deterred. During her first

year of doctoral study at Vanderbilt University in Nashville, Tennessee, Henry lived and worked in Atlanta and they commuted to see one another. As she finished her doctoral studies she decided that research and program development would be her first focus, never giving up the idea of practice but wanting to ground herself in science.



*Lorraine Williams  
Greene, PhD, ABPP*

She left Vanderbilt to work with Dr. Henry Foster at Meharry School of Medicine and became Deputy Director of Meharry's 'I Have A Future' program for African American youth. Because of her grant writing and research design skills, the program achieved national prominence and was named one of President George H. W. Bush's Thousand Points of Light. Dr. Foster went on to become President Bill Clinton's nominee for Surgeon General and Lorraine credits his losing nomination battle with showing her how important it is to "know the politics and watch the partisanship". It was then that she decided to deliberately broaden her community base.

For the rest of her life, she would be involved in her community through her church, her sorority, Delta Sigma Theta Incorporated, The Nashville Prevention Partnership and the Coalition of One Hundred Black Women, national and local service organizations. To these organizations she brought creative and resourceful talent to every project she undertook. After a year of internship

at the Psychological Services Unit of the Atlanta Department of Public Safety with Dr. Guy Seymour and Dr. Russell Boxley, she won a contract to offer services to the Nashville Police Peer Support program where she worked for nine years. Her work was so effective and well received that when Emmett Turner became Nashville Davidson County Police Chief in 1996, one of his first actions was to appoint her as the first Director of the Behavioral Health Service Division of the Department. She worked in this role until retiring in 2012 maintaining a focus on the behavioral health of police officers and their families.

In conjunction with Dr. Ellen Kirschman of California she wrote grants to establish a national program to provide accessible on-line support for police families and to provide mental health service support to officers from initial police academy training to in-service recertification. She has worked tirelessly to enhance psychology's offerings in the service of competent, fair, thoughtful and bias-free policing, including developing innovative cutting-edge training involving both community members and police and video vignettes related to decision-making to use violence in intercity scenarios. She also engaged in activities to reduce domestic violence and to combat efforts to suppress voting in local and national elections. Civil rights concerns and professional integrity were always at the core of her civic, social and professional activities.

In organized psychology she has been a powerhouse. She has served the American Psychological Association's Division of Psychologists In Public Service (18) first as Chair of the Police and Public Safety Section, then as the Division's representative to APA Council, and most recently was elected President-Elect of the Division. In 2014 she was given a Presidential Citation by APA President Nadine Kaslow for her dedicated service to law enforcement. Just this past August she was honored with the highest award the Division can make as the Harold Hildreth Awardee for Distinguished Public Service. She has also served on the executive boards of the American Board of Police and Public Safety Psychology, the Council Of Police Psychological Organizations, and held leadership positions in the International Association of Chiefs of Police, the Association of Black Psychologists and the American Red Cross.

More significant though than even the variety of her organizational service has been the fact that across all her

organizational service she was repeatedly described as "passionate", "insightful", "principled" and "courageous" and "balanced in her advocacy". Several colleagues praised her as "smart", "kind", "committed and generous, with her time, friendship and support". Her legacy is indeed "rich and deserving" of enduring recognition. In her career she has fundamentally improved the lot for police officers and their families and for communities, especially communities of color, which they serve.

Dr. Greene cherished her mother Grace, her husband Henry and her son Omari, the rest of her family and friends and reaffirmed it through meaningful engagements and the most thoughtful acts of kindness imaginable. With all of her professional activities, she was also very deliberate in maintaining the balance between work and family. At Unity Church she preferred to serve as a Greeter because she loved talking with the people. It was at Unity that she became aware of the 'Master Mind Principle' and how to use the tools of self-discovery, growth and transformation to embrace each day of life with efficiency and clarity of purpose. She formed a Red Hats Society Chapter and served as the 'Queen Mum'. She attended the Ebony Jazz Festival each year with family and friends and cruised with Tom Joyner. A few days before transitioning, she joined her sisters of the Nashville Alumnae Chapter of Delta Sigma Theta in honoring the Founders of that illustrious organization

Her values and principles, her commitment to actively living in the present, her positivity, and her fearlessness were most manifest in her long hard struggle against a very rare cancer, during which she never stopped fighting, and never stopped giving to her profession, community, and family and friends. Making a difference in the here-and-now, and living life fully and with gusto, were always her top priorities, and it was for these she lived. With gratitude, we honor Lorraine Williams Greene's life her, contributions, and her spirit.

*Guy Seymour, PhD*  
*Adrienne Bradford, PhD*  
*Bertha Holliday, PhD*

*In lieu of flowers, a contribution in her memory and honor can be made to: The Danita Marsh Scholarship For Women in Public Service, The Nashville Coalition of 100 Black Women Foundation. Inc., P.O. Box 331986, Nashville, Tennessee 37203.*



## Division 56 Member News

By: Vanessa Simiola and Amy Ellis

**Claudette “Claudia” Antuña, Psy.D., MHSA, LIC-SW**, submitted a symposium titled “Understanding assessments for Immigration Court and how to use the interpreter in determining trauma” that was accepted for presentation at the APA Convention in Denver 2016. This will be presented along with Leonara Cabrera, MA, a doctoral student at Fielding University). Dr. Antuña received the Washington State’s Psychological Association Social Issues Award, which was awarded on December 12, 2015 for her work in providing forensic evaluations to the Immigration Court and the Department of Homeland Security on behalf of immigrants seeking legal relief. Starting January 12, 2016, Dr. Antuña was recently appointed Chair of the Immigration Committee for Division 52 (International Psychology).

**Laura S. Brown, PhD, ABPP**, the 2010 president of Division 56, is announcing the release of her latest book, *Not the price of admission: Healthy relationships after childhood trauma*. The book, which synthesizes and integrates the wisdom of the field of trauma studies with Dr. Brown’s nearly 40 years of work with survivors of complex trauma, discusses pathways towards healthy relationships in which a survivor stops “paying the price of admission” for relationships through tolerance of abuse, neglect, exploitation, or devaluation. It reviews and synthesizes the trauma and attachment literatures, providing survivors with information about attachment, dissociation, trauma reenactments, and other relational dynamics that are affected by childhood attachment wounds. A free downloadable copy of the first chapter, as well as purchase options, can be found at [www.drlaurabrown.com/written/not-the-price-of-admission-healthy-relationships-after-childhood-trauma](http://www.drlaurabrown.com/written/not-the-price-of-admission-healthy-relationships-after-childhood-trauma). This is Dr. Brown’s second book for trauma survivors, and is an outgrowth of that first volume, *Your turn for care: Surviving the aging and death of the adults who harmed you*.



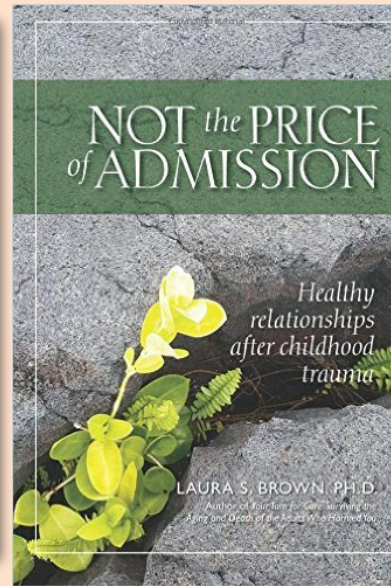
Laura S. Brown, PhD, ABPP

10th. For more information, please visit <http://www.traumatalks.ca/>

**Katy Dondanville, PsyD, ABBP, Brooke Fina, LCSW, Alan Peterson, PhD, ABPP and Joshua Friedlander, PsyD**, were accepted to present a Full-Day Continuing Education Workshop at the Annual Convention on Implementing and Adapting Treatment Protocols for PTSD with Active Duty Military Service Members. This workshop will describe treatment considerations and hands-on techniques for clinicians utilizing Prolonged Exposure and Cognitive Processing Therapy pertinent to treating military personnel with PTSD.

**Elaine Ducharme Ph.D, ABPP**, recently published a new book, *Assessment and Treatment of Dissociative Identity Disorder*, through TPI Press. This book gives

readers a basic understanding of the theory and research supporting the diagnosis of complex trauma and dissociative disorders and provides practical clinical recommendations for diagnosis and treatment, including options for integration. She presented an all day workshop on this topic at the Division 42 Fast Forward Conference in October of 2015.



**Michael Eigen, PhD**, received the Lifetime Achievement Award

from the National Association for the Advancement of Psychoanalysis. His new book, *Image, Sense, Infinities, and Everyday Life* was published this past December by Karnac Books. Here is a link to a description of his book: <http://us.karnacbooks.com/product/image-sense-infinities-and-everyday-life/37604/?MATCH=1>. And a link to what he says about it on karnacology: <http://karnacology.com/2015/11/01/image-sense-infinities-and-everyday-life-acts-of-shared-faith-by-michael-eigen/> A Festschrift in his honor with twenty contributors from all over the world was edited by Stephen Bloch and Loray Daws for Karnac Books: *Living Moments: On the Work of Michael Eigen*. It has a foreword by James Grotstein, one of the last papers he wrote: <http://us.karnacbooks.com/product/living-moments-on-the-work-of-michael-eigen/33821/>

**Charles Figley, PhD**, has an article currently in press titled “Risk and protective factors related to the well-

ness of American Indian and Alaska Native youth: A systematic review” to be published in *International Public Health Journal*. This article is one among a series of reports focusing on American Native Americans and their families in this region. There will be at least four more papers in the coming year or 15 months. Dr. Figley has also published a series of papers from an exhaustive analysis of hundreds of documents relevant to understanding why the US experiences these periodic crises of health care for war fighters and their families, led by trauma psychologist, Mark Russell, a fellow professor and colleagues at Antioch College in Seattle where he leads an institute focusing on combat stress injuries research and policy. Since 2013, Dr. Figley has been working with a team to transform his 2012 *Encyclopedia of Trauma: An interdisciplinary Guide*, into a series of courses. *Trauma!* is an undergraduate survey course that uses knowledge blocks (learning modules) developed by several dozen colleagues throughout the world who are experts in their area and in the Ency-

clopedia. This paper explains how the course emerged and similar game-based learning efforts such as Boston College: Moylan, G., Burgess, A. W., Figley, C. R., Bernstein, M. (2015). Motivating Game-Based Learning Efforts. *Higher Education Journal of Distance Education Technologies*, 13(2), 55-73, April-June. Dr. Figley has also published over 15 non-refereed publications over the past year.

**Ilene Serlin, PhD**, recently trained at the University of Hong Kong on 9/15/15, provided a training workshop for psychology interns at the Community Institute for Psychotherapy on “Embodiment and its application to work with trauma” on 12/11/15 and 12/17/15, and provided a training workshop at the American Dance Therapy Association on “Integrating the arts in building resiliency in regional contexts” on 10/24/15 in San Diego, CA. The latter workshop has recently been submitted as an article to the *American Dance Therapy Journal* and is in press.

## Meet the New Webinar Committee Chair: Dr. Jan Estrellado




*Dr. Jan Estrellado*

Colleagues, I'd like to introduce myself as the new chair of the Webinar Committee for Division 56. I am currently a Post-Doctoral Fellow at The Center for Stress & Anxiety Management in San Diego, California. I teach courses on stress management and trauma at San Diego State University. My research with Constance Dalenberg at the Trauma Research Institute focuses on trauma treatment issues related to ethnic minority individuals.

Under the leadership of the previous chair, George Rhoades, the webinars established an impressive track record and I am honored to continue leading our division in this work. The webinar series is free and open to the public, focusing on issues relevant to researchers, teachers, practitioners in the field of trauma psychology. We had a record-breaking turnout with our first webinar of the year featuring Dean Kilpatrick.

This year we will highlight the work of webinar presenters in the *Trauma Psychology News*. Expect to see previews and highlights of the webinars in future newsletters. If you would like to nominate yourself or another speaker for a future webinar, please email me ([dr.jan.estrellado@gmail.com](mailto:dr.jan.estrellado@gmail.com)). I hope to see you at the next webinar!





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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.

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

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

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- Access to the latest developments in trauma psychology
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- Member-only listserv provides ongoing communication with other members and breaking news of trauma-related developments in APA
- Opportunities to network with colleagues and potential collaborators through social hours and mentoring events
- Participation in the Division's annual meetings and voting privileges to elect representatives
- Eligibility to run for office, chair, and serve on Division committees and task forces
- Subscription to our journal, *Psychological Trauma: Theory, Research, Practice, and Policy*, at the member rate of \$22.50 per year

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An Official Publication of Division 56 of the  
American Psychological Association

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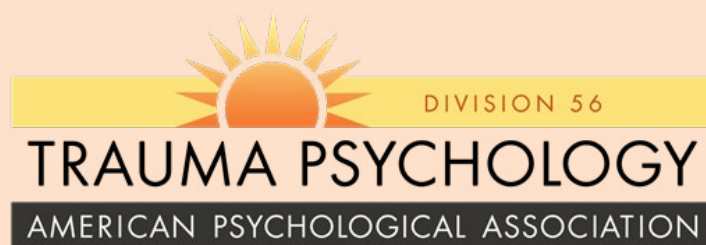
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Issue	Submission Deadline	Publication Date
Spring	February 1	April
Summer	June 1	July
Fall	October 1	November

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