



DIVISION 56

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

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PRESIDENTIAL VOICE

Sustaining a Vibrant Trauma Psychology Community

By Joan Cook, PhD

It's hard to believe that Division 56 celebrated its 10th anniversary this year. We started with a small group of individuals who believed that trauma deserved a greater role within the American Psychological Association (APA) and beyond. In a short period of time, thanks to the efforts of many, we have grown substantially and accomplished a lot. Indeed, our work has garnered excitement and enthusiasm from many. In just under 10 years, we've created a dynamic and thriving home. At our heart is the prevention of trauma, treatment of people with posttraumatic stress disorder (PTSD) and related disorders, advocacy for the needs of trauma-exposed populations, scientific study of trauma and PTSD, and education of professionals and the public about the effects of traumatic events. Over the past year, our membership numbers have continued to increase, in-

dicating the strength of our division; and the meaningfulness of the field of trauma and our journal continues to serve as a model to other divisions starting a journal.



Joan Cook, PhD

While it's important to recognize what has been done, it is equally important to recognize that much work remains. As we go forward in doing that work, we need to find ways to nurture and sustain a vibrant trauma psychology community. I can think of few better ways to do this than to bring

additional strong, caring people to the leadership table, attract and welcome new members, and engage all in a respectful exchange of ideas.

This year, we were fortunate to have many people join our leadership. Individuals who have been leaders in other organizations or programs but had not yet engaged as actively with APA and particularly our division. People like Julian Ford, Carla Stover, Terri deRoos-Cassini, Sonya

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Norman, Jessica Hamblen, Bekh Bradley-Davino to name a few. I am grateful for their willingness to come to the table and contribute significantly to our mission. I am also incredibly grateful, as I am sure many of you are, for the continued loyalty and service from those of our leaders who have been with the Division from the very beginning.

Our theme this year was “Trauma Psychology: Getting the Word Out.” One of our greatest associated accomplishments this year was the creation of printable fact-sheets and YouTube videos on the impact of trauma in underserved priority populations. Through collaboration with various APA divisions, we were able to create fact-sheets and accompanying videos for the following populations: older adults, male survivors of sexual assault, veterans, traumatically injured, ethnic minorities, Lesbian, Gay, Bisexual and Transgendered, economically disadvantaged, children and adolescents, and those with intellectual disabilities. These resources will be made available on our Division website and shared with APA for consideration on their YouTube channel. Thank you to everyone involved including Charles Figley, Sonya Norman, Terri deRoos-Cassini, Christopher Anderson, Jasmin Llas, Jan Estrellado, Julian Ford, Lesia Rug-

lass, Bekh Bradley-Davino, Amy Ellis, Robyn Gobin, and Nora Baladerian.

As this is my last presidential column, I’d like to extend a sincere thank you to all of you for giving me the honor of serving as president for 2016. Serving as president has been an extremely rewarding and enriching learning experience. Our Executive Committee includes deeply committed, intelligent people and it was a pleasure working with them this year. I particularly want to thank Drs. Amy Ellis and Vanessa Simiola for doing much heavy lifting this year -- at Convention (from helping to review abstracts to arranging every detail of the program and hospitality suite presentations), through spearheading membership efforts including a survey of member needs (if you haven’t completed the survey, please do so!) and the coordination of the interdivisional factsheets and videos design. I also extend my best wishes and support to Drs. Elizabeth Carrll and Diane Castillo, who will serve as president of the Division of Trauma Psychology in 2017 and 2018, respectively.

May our trauma psychology division thrive for another 10, 20, 30 years and beyond!

Trauma Psychology News has editorial positions open in 2017!

We have an opening for two positions beginning in 2017 and are looking for qualified applicants. Please see the descriptions below and send a letter of intent and CV to Bryan Reuther (btreuther@gmail.com) and Tyson Bailey (tdbaileypsyz@gmail.com) by January 31, 2017.

Associate Editor

- Must have strengths in providing developmental and copyediting feedback, with a focus on the former
- Good time management skills
- Will be responsible for reading and providing feedback on each article (5–10 articles per issue)
- Helping to develop themes for special issues and finding authors/editors
- Working with editorial assistant team to finalize the process
- Possible management of the web version (knowledge of WordPress is helpful)
- Time Estimate: 10 hours a week during a publication cycle (3 per year); time varies between deadlines

Editorial Assistant

- Responsible for managing the table of contents document
- Keeping Editor-in-Chief and Associate Editor on track for deadlines
- Searching for and creating the Who’s Who article
- Archiving the articles for each issue after publication
- Possible editing assignments based on need
- Possible management of the web version (knowledge of WordPress is helpful)
- Time Estimate: 5–10 hours a week during a publication cycle (3 per year); time varies between deadlines

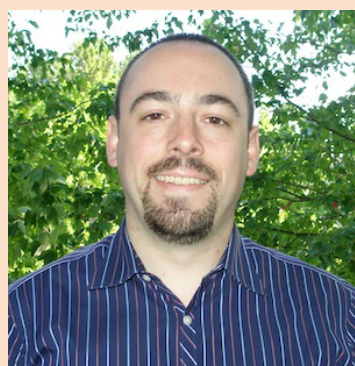
We look forward to reviewing applications, please let us know if you have any questions.

Sincerely,
Bryan and Tyson

Thank You



*Bryan T. Reuther, PsyD
Editor-in-Chief*



*Tyson Bailey, PsyD
Associate Editor*

I would like to personally thank Dr. Joan Cook for dedication and hard work during the past year. As a division, I believe we all feel fortunate to have had her leadership. My hope is that we all continue, in our own ways, her presidential theme of “getting the word out” about trauma in the coming months, years, and decades. While much was accomplished, more still needs to be done.

As we say our goodbyes to Dr. Joan Cook as our president, and she shifts into the position of immediate past-president, we welcome Dr. Elizabeth Carll, a longstanding leader in our division. We look forward to seeing her vision actualized in the coming year. And I am sure, unlike the current political climate, our transition of power will go far more smoothly!

TPN will also be going through some changes in the coming months as Dr. Tyson Bailey, our esteemed Associate Editor, will be stepping down. I profoundly appreciate Tyson’s commitment and hard work in making TPN a truly great publication for this division, and he will be deeply missed. He, of course, will remain extremely active in the division in other important roles. Thank you, Tyson, you will be missed here at TPN!

Hope everyone enjoys the next few months. Happy and healthy Holidays to all! See you in the New Year!

All the Best,

Bryan

Division 56 Member Services

Join Division 56: www.apa.org/divapp

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

Listserves: Everyone is added to the announce listserv, 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 (where discussion happens; membership is not required), send a note to listserv@lists.apa.org and type the following in the body of the note: subscribe div56

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

Newsletter: The newsletter is sent out on the division listservs and is available on the website at www.apatraumadivision.org/207/division-newsletter.html

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

Competent Care for Transgender and Gender Non-Conforming People is Trauma-Informed

By Cristina Magalhaes, PhD, Madeline Brodt, MS, and Jessica Punzo, PsyD

Transgender and gender non-conforming people (TGNC) face numerous challenges due to stigma associated with gender non-conformity, transgenderism, and transsexualism. In a landmark national survey with over 6,000 participants, researchers found that TGNC people experience alarming rates of discrimination, mistreatment, harassment, and physical and sexual abuse perpetrated by family members and other individuals in their communities – including educational, health care, and law enforcement professionals (Grant et al., 2011). Despite increased legal protections at the federal and, in some cases, at the state and local levels, deadly hate-motivated violence also disproportionately affects TGNC people, especially low-income transgender women of color, who experience multiple levels of social oppression and marginalization due to the compounding effects of racism, classism, sexism, and transphobia (National Coalition of Anti-Violence Programs (NCAVP), 2015).

Transphobia refers to intense feelings of disgust, repulse, fear, or dislike of all TGNC people—regardless of who they are as individuals—simply because their gender identity or gender expression does not match the gender they were assigned at birth, or because their sex anatomy is atypical or ambiguous. Common transphobic misconceptions about TGNC people include the beliefs that they are mentally unstable, anatomically aberrant, sexually deviant, morally defective, and dangerous to society. These beliefs are often used to justify mistreatment and victimization of TGNC people, who are deemed unworthy of respect and dignity as human beings. Kidd and Witten (2007) argue that abuse and violence toward TGNC people is a global phenomenon cutting across many cultures and nations. Unlawful arrests, violent assaults, gang rapes, murders, and other forms of abuse and violence motivated by hate have been reported in every continent – often in the name of family values and religion.

Clinical work with TGNC people, regardless of presenting problem, should therefore be trauma-informed. High rates of anxiety, depression, suicidality, substance use, and other symptoms associated with post-traumatic stress among TGNC people are well documented in the

literature, and are known to be associated with experiences of victimization (American Psychological Association, 2015). Clinicians should also remain aware that discrimination, abuse, and violence toward TGNC people impact not only individuals who are directly targeted, but the entire TGNC community, including TGNC family members and friends who remain vigilant and concerned for their loved one's well-being and safety.



Cristina Magalhaes, PhD

Resilience

Resilience is defined as successful adaptation to adversity and can be seen as a *trait* one possesses (or develops), a *process* that results in positive changes for an individual, or the *outcome* of effective coping. TGNC people can be resilient despite challenges. Considering high rates of victimization in the TGNC community, continuing to exist in the world as a TGNC person can itself be an indicator of resilience (Singh & McKleroy, 2011).

Several factors can build resiliency in TGNC individuals, including affiliation with the larger lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community (Bariola, Lyons, Leonard, Pitts, Badcock, & Couch, 2015; Singh & McKleroy, 2011). Though lesbian, gay and bisexual (LGB) social support has been identified as helpful in developing resilience in TGNC people, this effect can be magnified if positive peer support comes primarily from fellow TGNC individuals (Pflum, Testa, Balsam, Goldblum, & Bongar, 2015). Community engagement, such as organizing against discrimination or sharing stories of success, can also assist in fostering resilience in TGNC people (Asakura & Craig, 2014). Another well-documented resilience factor is family support. Family members have an important role in helping buffer the effects of social oppression and other stressors in the lives of TGNC people (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Working with family members to increase understanding of TGNC identity and gender non-conformity, and to improve relationships between TGNC people and their loved ones, can be instrumental in helping TGNC clients improve coping and increase wellbeing.

Furthermore, cisgender people (people whose gender identity or expression aligns with social expectations regarding gender) can also help foster resilience in TGNC people. One way is to help create safe and welcoming

environments for TGNC people in various settings (e.g., educational, health care, law enforcement, workplace), thus decreasing the amount of systemic oppression TGNC people experience in society at large. Cisgender people can also help identify, support, and contribute to TGNC affirming media and online communities, which have a wide reach – beyond constraints of geographic location – helping TGNC people anywhere in the world to feel stronger, fight back against minority oppression, and recover from experiences of victimization (Craig, McInroy, McCready, & Alaggia, 2015).

Clinical Implications

While the TGNC community is resilient and perseveres despite challenges, many individuals still struggle with serious emotional, behavioral, and substance use problems and seek services from mental health professionals to improve coping and increase functioning. According to the American Psychological Association (APA) Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (American Psychological Association, 2015), psychologists should strive to understand how mental health concerns may or may not be related to a TGNC person's gender identity and the psychological effects of minority stress. Given the alarming rates of violence against this community, it is not surprising that TGNC individuals would suffer from the vast sequelae of posttraumatic stress. Rates of both depression and anxiety are higher in TGNC communities than in the general population (Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2005; Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013). Additionally, estimates of lifetime rates of suicidal thoughts among transgender people range from 48% to 79% and estimates of suicide attempts range from 21% to 41% (Hopwood & Dickey, 2014). These rates are much higher than national averages, which range from 1.9% to 8.7% for adults who attempt suicide (Nock et al., 2008). Substance use problems are also common; research findings indicate that TGNC individuals turn to drugs and alcohol to cope more frequently than cisgender individuals (Lombardi, 2008; Grant et al., 2011; Testa et al., 2012).

Another reason TGNC people seek mental health care is to obtain support for gender transition, which may include a request for a recommendation letter to start hor-

mone replacement therapy or undergo gender reassignment surgery. Although the need for mental health professionals to be in this type of gate-keeping role seems to be decreasing in recent years, some TGNC clients still seek care specifically for obtaining a letter for surgery, and clinicians should follow the World Professional Association for Transgender Health (WPATH) guidelines when asked to provide this type of service (see list of resources below).



Madeine Brodt, MS

While the cultural implications of working with TGNC clients are complex and unique, many practicing psychologists who serve TGNC clients have had no formal training in TGNC-specific issues, with very few graduate programs addressing the needs of this population within academic curriculum. In 2009, the APA Task Force on Gender Identity and Gender Variance survey found that less than 30% of psychologist and graduate student participants had some familiarity with issues that impact TGNC people (American Psychological Association, 2009). A critical need remains for cultural sen-

sitivity, especially around historical psychopathology of transgender identities, such as the introduction of a gender diagnosis in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980. Gender Identity Disorder (GID) was re-conceptualized and renamed as Gender Dysphoria (GD) in the DSM-5 with the intent to be less pathologizing of transgender identities (American Psychiatric Association, 2013). However, professionals must be aware that TGNC people still need to be diagnosed with a mental disorder (i.e., GD) to access gender-related care, which inherently affects how TGNC people are treated in health care settings and how they feel about themselves. Furthermore, numerous studies have noted that transphobia is a significant barrier to competent care within the mental health system. TGNC people often report feeling disrespected by and receiving poor care from health care providers, including mental health professionals, which causes many to avoid accessing services altogether (Shipherd, Green, & Abramovitz, 2010; Lucksted, 2004; Colton Meier, Fitzgerald, Pardo, & Backcok, 2011; Kidd, Veltman, Gately, Chan, & Cohen, 2011).



Jessica Punzo, PsyD

Clinical and counseling psychologists are trained to assess for emotional and behavioral problems, and to help individuals restore wellness when feeling distressed

and depleted of resources for coping. They can be of great help to TGNC people, many of whom struggle with complex trauma stemming from personal and/or community histories of marginalization and victimization. Competent transgender care is, first and foremost, affirmative of TGNC identities, but also grounded in a clear understanding of the lived experiences of TGNC people and the need for trauma-informed services that center around fostering resilience and improving coping.

Resources

Introducing the reader to the full spectrum of issues that impact clinical practice with TGNC clients is beyond the scope of this article. The American Psychological Association (APA) website has a page with several resources for psychologists interested in learning more about TGNC people and their needs, including links to the *2008 Report of the Task Force on Gender Identity and Gender Variance*, the *2015 Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, fact sheets, a continuing education course, and other excellent resources (<http://www.apa.org/pi/lgbt/programs/transgender/>). For more specific information on interdisciplinary gender-related care (i.e., how to work with other health care professionals to support TGNC clients through gender transition), clinicians are referred to the 7th edition of the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* developed by the World Professional Association for Transgender Health (WPATH) which is found at http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351. Several excellent articles and books are also available, as well as websites maintained by well-known organizations, which can offer clinicians a broad understanding of issues impacting the TGNC community, including barriers to care. Here we list a few that we believe you will find useful.

- Brill, S. A., & Kenney, L. (2016). *The transgender teen: A handbook for parents and professionals supporting transgender and non-binary teens*. San Francisco, CA: Cleis Press.
- Brill, S. A., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. San Francisco, CA: Cleis Press.
- Erickson-Schroth, L. (2014). *Trans bodies, trans selves: A resource for the transgender community*. New York, NY: Oxford University Press.
- Gender Odyssey (<http://www.genderodyssey.org/>)
- Lev, A. (2008). *Transgender emergence: therapeutic guidelines for working with gender-variant people and their families*. Binghamton, NY: The Howarth Clinical Practice Press.
- National Center for Transgender Equality (<http://www.transequality.org/>)

www.transequality.org/

- Singh, A. & dickey, I. (2015). *Affirmative counseling and psychological practice with transgender and gender nonconforming clients: Perspectives on sexual orientation and gender diversity*. Washington, DC: American Psychological Association.

References

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Jessica Punzo, PsyD, is a licensed clinical psychologist and Director of the Anti-Violence Project at the Center on Halsted, the Midwest's most comprehensive community center dedicated to securing the well-being of LGBTQ people within Chicagoland, IL. The Anti-Violence Project provides support to LGBTQ survivors of violence through counseling and advocacy. Dr. Punzo is also an adjunct faculty member at The Chicago School of Professional Psychology. Her clinical and research interests include aspects of sexuality/sexual functioning that are affected by sexual trauma, the impact of trauma on spirituality, specific needs of bisexual individuals, and the efficacy of evidenced-based trauma therapies within the LGBTQ community.

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.

Social Media News

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

There's More

By Michael Eigen, PhD

I ask Ravi, someone who rages at his wife. "Are you like that at work too?" He said, "No, no, not like that at work." Recently he said he rages only at his wife, not his kids. So I asked, "What would happen if you treated your wife as a child?" I was trying to support him. He thought about it. I told him how actors feed their energy, whatever they might feel, into the role they played and added, "If you're lucky your feelings will change, but for the time being maybe we can help you be a better actor."

"Fake it till you make it?"

"Yes."

"I don't have it."

"Make believe you do." We discuss the possibility that over time practice makes it work. Changing behavior can change feelings as well as vice versa. It works both ways. I wrote about a variation of this in the second chapter of *Coming Through the Whirlwind* (1992): affects and attitudes go together. There is no such thing as an affect without an attitude without affect. Gestalt Psychology speaks of attitudes as frames of reference for feeling and behavior. You can approach it from either direction. I remember Alan Watts talking about his Zen practice and how he grew by faking states he hoped to achieve. He felt this practice made him a better person than he would have been otherwise. One may wonder what that may mean as alcoholism contributed to his, as to R.D. Laing's, early death. Both inspired many. One does not become wound-free to be of help. Watts often lived an inspired life, lifting himself beyond what he might have accomplished otherwise.

Ravi doubted his capacity to be what he wanted. I won't disillusion you now by saying I doubt we know what to be or how. The idea of "the American dream" I find stultifying and sometimes mean, often allied with narrow, self-persecutory ideas of the human. So much lived experience is "out of the box". Can we credit it, appreciate it?

"Practice makes perfect," is a phrase I heard throughout my childhood. If I was going to do anything, it would be imperfect. In fact, perfect would have to drop away as a consideration. One learns to give oneself over to the moment and what arises, might arise. Something comes through – what is that something? Nevertheless, practice has importance. Practicing opens paths. Practicing

to be yourself goes on all life long.

I could not have written a word if perfection was an aim. Maybe some would have preferred that. Nevertheless, it is good to be able to use oneself, exercise some of what is there, however flawed and inadequate. There are ways being inadequate can be freeing, doing what one can, a little bit of what presses to be shared.

Urging Ravi to fake it had years of trial and error behind it. Encouragement to begin the awful business of practicing to be himself, even if that is impossible. The impossible is a different category from the perfect. A little bit of the impossible goes a long way. Creativity is, partly, a venture of the possible at the edge of the impossible. Giving birth doesn't require perfection, just life.

One day Ravi began, "I started reading *Rage* – finally. You suggested I look at it three years ago. I don't know, I came upon it while dressing after a run and shower. It was under my bed. The red-orange-black cover with big white letters RAGE staring at me. Had it been there all this time? RAGE is printed twice, white RAGE on dark RAGE.

Red, black, and white rage. Maybe I should just stare at the cover. How could it be under my bed and I not open it all this time?"

"Things have their moments..." I say.

Ravi was quiet for some time. "Maybe I'm waiting for my moment." He seemed to be searching for something. "Or my moment is waiting for me," he added.

"I believe in moments," I joined.

"I have a feeling you believe. All the time we spent and I still..." his voice trailed.

"You are more than the sum of your rage, more than the sum of your parts." I was thinking of a meditation leader who said, "You are and are not your mind. You are and are not your body. You are and are not your ..."

"Parts don't sum. There's something more. Looking at your book brought back my father's rage, my mother's fear. When flare-ups came I felt them both. Caught between rage and fear. They marked me. I think of the mark of Cain, not because he killed his brother, that's bad enough, but because murder is with us. We are Cain



Michael Eigen, PhD

getting murdered and murdering. Is that the final word?”

“Caught in trauma worlds that go on and on. Yet do you remember, Cain became a builder of cities? Did trauma make him a builder?”

“Horror doesn’t go away. Yet building happens, life goes on building, ripping, more building. I had a teacher who said destruction and building go together. But we get stuck. I feel the pain of my wife. My rage is painful. You nail my feeling of self-righteous rage, the rightness of rage. I’ve met people who can’t say anything good without putting a person down. The rightness of rage comes from feeling wronged. Now everyone else is wrong and I am right.”

“Imprisoned by right and wrong.”

“Yes – the prison of right and wrong.” Ravi was quiet awhile. “Your book brings out other possibilities. No solutions. It got me to think of so many other things in my life, good moments with my wife. I’m not a rager all the time. I’m not scaring myself and others all the time. Fear is part of me, shame, rage. But there’s more, a lot more.”

“As time goes on, maybe the rage will take up less room.”

“It already does take up less room. I hope that continues. I think of trauma worlds that are part of us. I think

trauma is with us all life long. I don’t see how it can be otherwise. It is part of us.”

“It gives me a deep feeling when you say that. Trauma is part of us, part of who we are, life itself.”

“It is us. We are trauma. But that’s not all we are.”

Ravi is weeping and I feel weepy too. We are both in a process of recovery that never ends. It is as if the quality of being changes, a shift in the quality of one’s sense of being.

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Michael Eigen, PhD, is author of twenty-six books including *The Psychotic Core*, *Flames from the Unconscious: Trauma, Madness and Faith*, *Contact with the Depths*, *Feeling Matters*, *The Sensitive Self*, *Faith*, and *Under the Totem: In Search of a Path*. His teaching, editing, and supervision experience spans across many institutes and universities worldwide, with the past twenty-five years at the National Psychological Association for Psychoanalysis and the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis. He gives a private seminar on Winnicott, Bion, Lacan as well as his own work, which covers active research for over forty years.

International Committee

By Elizabeth Carll, PhD, Chair

As part of the series of interviews conducted by student members with trauma psychologists from various parts of the world, Christabel Leonce, a student member of the International Committee, interviewed Dr. Brigitte Khoury, a psychologist in Lebanon. Khoury works with various forms of trauma, including with individuals from the surgery department at the American University of Beirut Medical Center where she works.

To encourage the participation of international students at the APA convention, the Division approved an annual \$1000 student stipend and complimentary convention registration to support the travel of a student, from a developing country, who has a trauma-related poster or paper accepted for presentation at the convention. The 2017 APA Convention will take place in Washington, DC. A free one-year membership in Division 56 is also included. Candidates interested in the travel stipend should contact: Dr. Elizabeth Carll, Chair, Division 56 International Committee, at ecarll@optonline.net

Considering the emerging global immigration crisis, a special initiative was organized and is reported in another section of the newsletter.



Elizabeth Carll, PhD

An International Committee Interview with Dr. Brigitte Khoury

By Christabel Leonce

Dr. Brigitte Khoury is a clinical psychologist in Beirut, Lebanon and has been a leader in the field of psychology since receiving her doctorate from Palo Alto University, California. Khoury served as the founding president for the Lebanese Psychological Association (LPA), shaping the way psychology is practiced in Lebanon by helping to establish practice guidelines, rules, and regulations. She is also a faculty member at the American University of Beirut (AUB) in the area of trauma psychology.

Khoury's passion is evident as she describes her current work alongside the surgeons at AUB—specifically, to bring hope to military personnel who have been victims of trauma-related accidents such as bombs, suicide bombings, and shellings. The psychological services Khoury and her team provide are unique to the Arab region. She sees military personnel from Iraq, Pakistan, Afghanistan, and Syria. Khoury has been working at AUB since completing her post doctorate training at Stanford University. However, it was not until about four years ago that she began to collaborate with the surgery department to provide holistic rehabilitation to patients seen for reconstructive surgery at AUB.

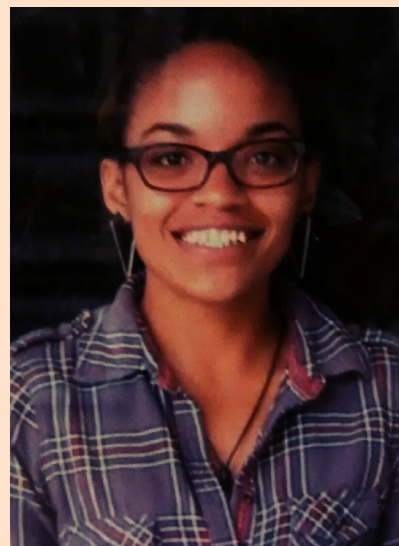
Khoury describes the partnership as something that was very much needed because military personnel were indeed traumatized by exposure to war, injury, and also the experience of undergoing surgery, which comes with its own unique challenges. She explains that her collaboration with the department of surgery is one that provides a holistic team approach to provide surgery, mental health, physical therapy, and many other basic services to the patients.

When asked about the relationship between her team and the patients, Khoury explains that the relationships can become very close, as team members may work alongside each patient for almost a year. She describes Middle Eastern society as being based on two things: family and religion. Therefore, she strives to be sensitive

to these foundational needs of her patients, as well as their mental health needs, by creating space to practice religious customs as needed during their stay at the hospital, and by surrounding them with family members that can make the trip to Beirut. She also makes herself available to the family members, and prepares her patients to go home to be with their families again by having them call or Skype with children, and to resume their prior roles as fathers or leaders in the community.



Dr. Brigitte Khoury



Christabel Leonce

Khoury describes her first encounter with a patient as being a social meeting that helps develop trust. She does not begin to speak of the traumatic incident until the patient is ready to speak. Patients are usually at the hospital for three to six months and occasionally for up to one year. Khoury points out that the duration of the service provided allows her to foster a close relationship with her patients, in which she experiences their highs and lows with them. She describes the experience of mental health service as different from how we see it practiced in the USA, where such a relationship is also central, but not as engrained within the treatment process.

Khoury spoke of providing support to family members who have travelled far from the home to be with the patient. The process is also stressful for the family, especially the spouse—often the wife—who is away from her children and friends. Khoury explains that though the journey may be long, it's very rewarding to see her patients move holistically towards a new life; not better than before, but with the skills to adjust to living in society despite the accident they experienced. She expressed how happy patients appear when they come back for a regular check-up, and Khoury derives satisfaction from seeing the patients cope well with their new realities.

When asked about mental health in the Middle East and how often people seek out a psychologist, Dr. Khoury responded that it is not likely that her patients will continue to seek services when they return to their hometowns, due to the stigma attached to mental health and psy-

chology. She did assure that the context is improving as people become more aware of mental health through the media. The World Health Organization has been working to bridge the gap in services by training primary care service providers to offer basic mental health services. Training for primary care providers has been beneficial because people will first see a medical doctor for somatic symptoms, before visiting a psychologist.

Khoury says that working in trauma psychology in the Middle East can be stressful. She advises young psychologists who may consider working in the field to have an open mind, and to learn as much about the culture you are entering as you can. She also stressed the importance of having advisors and colleagues who are already in the field, and a great support system, to prevent the burnout that may occur when working with this popu-

lation. She also emphasizes the importance of cultural sensitivity and awareness and the need for psychologists from Western cultures to learn about non-Western cultures. It is especially helpful to learn from persons who are already working in the field, before attempting to implement change.

***Christabel Leonce** is a graduate student in the Clinical Psychology Program at George Fox University. She is a student member, from Trinidad and Tobago, of the International Committee of the APA Division of Trauma Psychology. Her research interests center on Adverse Childhood Experiences in parents and how this impacts attachment and parenting styles in her home country. She is also interested in working with children on the Autism spectrum and children with cognitive developmental delays.*

Invitation to Participate: 2017 Presidential Initiative to Respond to the Mental Health Needs of Refugees

By Elizabeth Carll, PhD, President-Elect

As forced migration due to wars, conflict, and persecution worldwide continues to unfold, the number of people displaced within their country or having fled internationally has reached more than 59.5 million—the highest level ever recorded, according to estimates by the United Nations High Commissioner for Refugees (UNHCR).

Refugees and migrants face dire and uncertain futures. Lebanon has the highest number of refugees per capita, hosting more than 1.5 million Syrian refugees. The United States is the world's top resettlement country for total number of refugees. In Kenya, with the anticipated close of the Dadaab Camp, many Somali refugees worry about deportation and may feel they have no alternative than to return to their homeland to dire and sometimes dangerous situations.

In September 2016, world leaders convened at UN Headquarters for the UN Summit for Refugees and Migrants to address the challenges of this worldwide crisis. Also participating in the summit were refugee support and advocacy organizations, refugees describing their experiences and civil society.

Migration for all reasons including economic and environmental/climate factors is a global phenomenon with approximately 244 million international migrants in 2014, according to the UN Dept. of Economic and Social Affairs. This large-scale global migration is anticipated to continue for many years.

Mental health and psychosocial responses are increasingly important components of programs for crisis-affect-

ed migrants seeking asylum and refugee resettlement. There is a great need for these services and often the demand for mental health professionals far exceeds the supply. To help meet these needs, I have recommended the development of a Refugee and Mental Health Resource Network to develop a database of volunteer psychologists, within the US and globally, to help fill the need for evaluations and support services. We need your help to accomplish this humanitarian goal. This is an interdivisional initiative and all are welcome. Due to increasing needs, it is also a multi-year initiative. In order to help support the creation of the database and related activities, an APA CODAPAR grant proposal was submitted and will be determined by December 2016.

If you have experience working with refugees and have also conducted evaluations, such as asylum evaluations, we especially need your skills. **Due to a computer problem with both incoming and outgoing emails for approximately six weeks during the summer, emails from interested members sending information regarding their desire for participation in the network database may not have been received. If you have not received a response, please resend your email, as we may not have received all communications.**

Training will also be offered to familiarize psychologists who are experienced in working with trauma and interested in volunteering, who may not have experience and specialized skills working with refugee and migrant populations. If you are interested in volunteering and would like to be included in the database being created, please contact ecarll@optonline.net.

Clinical Considerations for Moral Injury, Rational Guilt, and Combat PTSD

By Rob Chester, MA and Rebecca Temple, PhD

In working with Veterans diagnosed with posttraumatic stress disorder (PTSD), we have noticed the evidence-based treatment approaches most often used, such as Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT), may not address all symptoms, even after extensive trauma processing. Some Veterans indicate they continue to struggle with issues such as difficulty with social engagement, emotional vulnerability, mistrust, guilt, anhedonia, and anger, even after the fear-based symptoms (i.e. anxiety, hypervigilance, exaggerated startle response, etc.) have diminished (Steenkamp, Litz, Hoge, Charles, & Marmar, 2015). Clinicians with significant experience working with Veterans with PTSD will likely know how to address these symptoms during the course of treatment; however, the manuals for PE and CPT do not provide explicit guidance on how to do so. In this article, we will describe the importance of recognizing moral injury in trauma, and the guilt and shame that may be embedded in it, as well as address some clinical considerations.

Shay (1995) notes that guilt and shame may stem from a moral injury, which he defines as a betrayal of rightness, in a high stakes situation, by a person in authority. Litz and colleagues (2009) conceptualize moral injury as a distinct component of trauma that stems from actions, or observations of others' actions, that violate his or her own personal moral code and expectations for behavior. Veterans may experience ethically ambiguous situations that require split-second decisions, including being ordered to engage in behaviors that violate their sense of right and wrong, or witnessing others engaging in these acts (Litz et al., 2016). These moral and spiritual issues occur due to exposure to the traumatic event, yet they are distinct from the problems that arise due to exposure to the life-threatening nature of many traumatic experiences. However, the two are not mutually exclusive. Veterans experiencing a moral injury share many of the same symptoms as Veterans with PTSD who have not.

Importantly, there are differences in how Veterans with PTSD and moral injury experience guilt and shame. Some Veterans may interpret guilt and/or shame as a rational and contextually appropriate consequence of their actions during a traumatic event. Other Veterans may

experience guilt and/or shame that is illogical, irrational, and inappropriate given the circumstances of the trauma. The authors' anecdotal experiences are consistent with literature identifying appropriate guilt and shame as symptoms that go beyond the current diagnostic criteria for PTSD, yet are often embedded in a person's trauma (Shay, 1995, 2014; Litz et al., 2009, 2016). Inappropriate guilt and shame were added as new PTSD symptoms in the DSM-V, but *appropriate* guilt related to decisions made (or not made) in ethically and morally ambiguous situations is not yet being reflected in our current understanding of PTSD (APA, 2013).

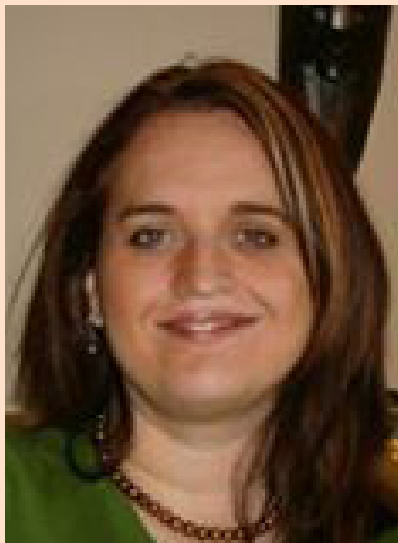
Guilt is a negative evaluation of a specific behavior associated with remorse and regret over real or imagined threats to one's relationship with those harmed by the specific act (Farnsworth, Drescher, Nieuwsma, Walser, & Currier, 2014). It is context specific, and often does not involve a global reevaluation of one's character. Shame is a negative evaluation of behavior which is then generalized to all facets of one's identity, accompanied by feelings of worthlessness, vulnerability and hatred of the self (Farnsworth, Drescher, Nieuwsma, Walser, & Currier, 2014).

Decades of research (Steenkamp, Litz, Hoge, Charles, & Marmar, 2015) have shown effective ways to clinically address the symptoms of PTSD. However, the identification and treatment of moral injury are relatively new. Nascent trauma treatments are

examining the spiritual and moral facets of PTSD that can be hidden in traumatic experiences. An emerging treatment is Adaptive Disclosure (AD). This treatment helps the Veteran to modify understanding related to the trauma, consider alternative perspectives, and forgive themselves. It is meant to provide opportunities for meaning-making, while fostering reparation and atonement (Litz et al., 2016).



Rob Chester, MA



Rebecca Temple, PhD

To illustrate the concept of moral injury, a case study is offered that is infused with a violation of morality that occurs alongside an experience based in fear:

The Veteran was a 19-year-old gunner on an OH-6 Cayuse “Loach” helicopter in Vietnam. The purpose of Loach missions is to draw fire from concealed combatants and to take fire orders from the Command and Control aircraft (C&C) flying above them. The Veteran had been on hundreds of similar missions, killing an uncounted number of combatants. During one mission, the Veteran’s Loach was flying in a free fire zone and was alerted to an unarmed male working in a rice field. The Loach was directed to approach this man. The Veteran asked for identification, and the man signaled that he had none. The C&C told the Loach pilot to order the Veteran to kill the man. The pilot refused to convey the order. The pilot was told a second time to kill the man and he finally relayed the message to the Veteran. The Veteran hesitated, as the man was unarmed and this was against the rules of engagement and both the pilot’s and the Veteran’s personal moral code. Again, the pilot ordered the Veteran to kill the man. This time, the Veteran looked the man in the eye, said “xin loi” (“I’m sorry”), and fired two rounds into his head and chest. The pilot and the Veteran discovered later that the South Vietnamese colonel in the C&C wanted a kill during this mission in order to improve his chances of promotion. For decades, the Veteran saw the man he killed in his dreams—always his confused face as he was shot. The Veteran abused alcohol for the next several decades and worked incessantly. He isolated himself and was afraid of his own anger. He attempted suicide on multiple occasions and expressed hatred for himself.

In the case example above, we see a Veteran struggling with guilt and shame, both core symptoms of moral injury. These are two distinct but related emotions impacting the prognosis of PTSD in different ways. Nazarov et al. (2015) found that these intense feelings often lead to behaviors which are meant as punishment, such as self-injurious behaviors, self-deprecation, and self-alienation.

We hypothesize that these behaviors may be unconscious and unproductive attempts at atonement or reparation for the irredeemable losses one caused. When a person engages in internally-focused punishment, his or her behaviors are self-destructive and often cyclical. The Veteran in the case example focused on punishing himself for killing an unarmed man. He was reminded of his behavior when the unarmed man appeared in his dreams. He punished himself through isolation, used alcohol as a way to numb himself, experienced self-alienating anger and violence, and attempted suicide multiple times. Through processing and self-examination in therapy, he discovered that shame and guilt fueled his self-imposed punishment. The Veteran was in a dangerous situation and reported concordant fear; however, his feelings of guilt and shame were the most distressing symptoms he experienced. Interestingly, the Veteran refused to engage in CPT and PE for treatment because a part of him believed that he did not deserve to get better. He believed that his suffering was his atonement.

In the authors’ clinical experiences, initial attempts at

atonement are often expressed as self-directed punishment rather than other-directed atonement (i.e. engaging in positive activities outside of oneself and directed at others in an attempt to make up for perceived transgressions). In processing moral injuries, individuals are encouraged to engage in other-directed atonement by finding a productive way to channel the energy behind the guilt and shame. The Veteran in the case example eventually decided to move away from self-directed punishment and towards other-directed atonement. Now, he is using his passion for fishing, specifically in teaching people to fish. He has donated money to mine clearing operations in Vietnam in an effort to atone for his perceived transgression. It may be appropriate and rational to feel guilt for killing an unarmed man. However, it is irrational for this Veteran to believe that he had complete control and ultimate decision-making authority in that situation. It is also notable that people who feel shame, or have the thought “I am bad,” are displaying signs of a good self by merely engaging in a moral evaluation of themselves. Essentially, bad people are not likely to worry about being bad people.

The coexistence of moral injury and trauma has been found to be associated with the most severe and chronic types of PTSD (Drescher et al., 2011). Therefore, it is imperative that clinicians recognize moral injury and provide avenues for atonement aimed at redirecting self-focused punishment into other-focused reparation for those experiencing rational and appropriate guilt. We believe that this work can be done concurrently with trauma treatments, such as PE and CPT, or as a stand-alone treatment specifically directed at moral injury.

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Robert A. Chester, MA, is a Clinical Psychology Psy.D. student at William James College in Newton, MA. He is currently working as a Doctoral Psychology Intern at the Gulf Coast Veterans Healthcare System- Joint Ambulatory Care Center in Pensacola, FL. Mr. Chester is an Army veteran with experience as an enlisted combat engineer and as medical service corps officer. He is passionate about helping his fellow veterans recover from PTSD, substance use disorders and homelessness.

Breaking the Ice: Interdisciplinary Treatment of Sex and Intimacy Issues in Veterans With Co-Morbid TBI and PTSD From the Iraq and Afghanistan Conflicts

By Nicole R. Randall, MA, and Matthew Golley, MS

We are Veterans of the US Marine Corps and clinical psychology doctoral-trainees working with Veterans from the Iraq and Afghanistan conflicts within Veterans Affairs (VA). Within our clinical work, we noticed a myriad of sex and intimacy (S&I) issues that frequently occur in conjunction with posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI; Hirsch, 2009; Turner, Schöttle, Krueger, & Briken, 2015) that are often beneath the surface of clinical attention. This paper will review relevant literature and discuss how we utilized this information to create an interdisciplinary treatment group

A study by Mackenzie, Alfred, Fountain, and Combs (2015) found that for survivors of TBI within the general population, intimacy was their third most important unmet need. Another study found that between 35-75% of Veterans with PTSD report significant intimacy problems (Katz, 2008). Further, Nunnink, Goldwaser, Afari, Nievergelt and Baker (2010) demonstrated that as many as 80% of Veterans with PTSD reported clinically significant sexual problems, which were found to be most closely related to PTSD's emotional numbing symptom cluster.

These S&I issues lack clinical attention partially because of clients' reluctance to report them to providers (Lindau, Surawska, Paice, & Baron, 2011) and partially,

we suspect, because of providers' reluctance to ask. We felt some hesitation to discuss these topics, due in part to our preconceived notions of privacy, as well as our concerns about our own lack of clinical knowledge in this area. However, after immersing ourselves in the

literature, we realized how important these issues are in the treatment of Veterans. Despite the lack of attention these issues receive in therapy, they remain serious concerns for clients. As Veterans, we were impassioned to shine light on these issues because we are in a unique position to understand the nuances of S&I issues from a military cultural standpoint. We therefore chose to create a novel group-based intervention to function as an avenue for discussing common S&I issues.

We decided to develop a psycho-educational group protocol. We aimed to "break the ice" on the topic of S&I and to open a line of communication between clients and providers. We decided to incorporate discussion, activities, guest speakers, and optional readings for multi-modal delivery of

information. To address these complex issues in multiple domains (e.g. intimacy, attitudes about sexual activity, sexual functioning, medical and psychological implications), we utilized Feminist Theory (FT; Friedman, 1963) and Social-Constructionist Theory (SCT; Berger & Luckman, 1966). These theoretical frameworks were essential in elucidating the social and interpersonal contexts from which many of our clients' S&I issues stem.



Nicole R. Randall, MA

An Integrated Theoretical Approach to Treating Sex and Intimacy Issues

We chose to incorporate FT to examine social-gender roles, gender inequality, patriarchy, and stereotyping (Friedman, 1963). Initially, we felt unsure using FT with combat Veterans because we did not want to appear confrontational or politically motivated due to clients' possible misperceptions of Feminist principles. Luckily, our clients openly used feminist principles of gender equality to not only gain insight into patriarchy and stereotypes, but also liberate themselves from these. For example, one client who stated that he had never questioned certain stereotypes about himself as a male, shared that this protocol facilitated growth in his self-concept. We discussed how Feminist Theory could elucidate the cultural context from which gender oppression continues to be an issue for service-members (Burke, 2004). Compulsory masculinity denies both sexes opportunities to express and utilize the full range of human emotions, requiring through social pressure, preference for typically masculine emotional displays and behaviors. Service-members are commonly discouraged from displaying traits that are culturally defined as feminine for fear of compromising perceptions of strength and unit cohesion, thus promoting hyper-masculinity (Rosen, Knudson, & Fancher, 2003). One client exemplified the relational distress that often results from hyper-masculinity by sharing, "I feel like I can't ever show weakness, and I know it's affecting my marriage."

Broadening the discussion, we incorporated SCT, which helped clients examine how processes like military indoctrination, combat experiences, and their civilian communities influenced their socially constructed assumptions and beliefs about themselves and others. One client described how his identification with his warrior identity, conflicted with his civilian role of husband. He had been treating his family like they were in the military, as he was blending his dual roles. Following the presentation of SCT, he acknowledged how he carried over beliefs and expectations from the Army to his home life. This added insight allowed him to adapt his interaction style and beliefs to civilian society, identifying and modifying his interactional patterns as they carried over into his intimate relationships (Hedges, 2005).

Integrative Approaches to Treating Sex and Intimacy Issues

We recruited eleven male Veterans from an inpatient program for co-occurring TBI and PTSD. When we surveyed participants for input on group content we dis-

covered that S&I issues were a significant area of need. To evaluate our intervention, we assessed prevalence of S&I symptoms, comfort with discussing S&I concerns, and knowledge of content domains including: PTSD/TBI impact on S&I, medication side-effects, and treatment options.



Matthew Golley, MS

Our curriculum covered: cultural impact on S&I, intimacy types, first steps in rebuilding intimacy, common sexual dysfunctions, medications/side-effects, and treatment options and resources. The first session focused on culturally-derived values and expectations and their influence on the acceptability of sexual practices. We were surprised to see the variety in clients' reactions to gender stereotypes, the impact of religion, and the range of cognitive flexibility they demonstrated as a group. We initially expected more similarity between responses given the relatively homogenous nature of our sample with regard to sex, age, ethnicity, and SES, we expected more similarity. We were also delighted to see how open-minded everyone was and how enthusiastically they discussed personally intimate

details like sexual preferences and disavowed previously held stereotypes, all in the first session.

The second session normalized S&I-related symptoms and disorders, which frequently co-occur as sequelae of PTSD, TBI and military sexual trauma (MST; Hirsch, 2009; Turner, Schöttle, Krueger, & Briken, 2015). We created a handout for Veterans to share with their partners which described common symptoms including erectile dysfunction, decrease in libido, emotional numbing, avoidance of physical touch, and unintentional merging of aggression and violence within the context of physiological and psychological arousal (American Psychiatric Association, 2013). Clients were especially interested in the sexual response cycle (Leiblum, 2006), as many of them struggled with erectile dysfunction. We also introduced treatment options and referrals.

In the third session, clients engaged in a group discovery exercise on types of intimacy including emotional, intellectual, physical, and sexual. After they each gained the vocabulary to describe their personal preferences, it was interesting to see how each Veteran compared himself to other group members, as well as openly discussed his speculations about preferences of their partners. When two clients stated that they would share their handouts with their partners in order to identify ways to meet each other's needs, we excitedly realized our clients were becoming increasingly empowered.

For the final three sessions, we invited guest speakers (e.g., pharmacists, nurses, and physical therapists) to

share their expertise based on requests by clients during the design phase. Our most popular guest speaker was our pharmacist. She presented in-depth information on common medications prescribed for PTSD and TBI and their sexual side-effects. This topic was highly relevant and had an apparent effect on clients' self-advocacy. After this session, our nursing staff and prescribers saw an immediate increase in the proactive solicitation of information regarding their prescriptions and collaborative discussion of alternative and adjunctive therapies.

Results

Overall, the group was a success. Providers and clients expressed their appreciation of gained information in an underutilized focus of treatment. Several clients requested individual follow-ups with specialty providers and some began direct conversations with partners. All clients reported that the group was worthwhile with 75% requesting group extension. Based on self-report, relevant knowledge increased across domains; including how PTSD affects S&I, TBI's impact on S&I issues, medications and S&I, and S&I treatment options. In fact, many of our participants reported little or no knowledge in the domains at pretreatment and a majority of our participants reported attaining knowledge in each domain covered.

Conclusions and Future Directions

We were surprised at how comfortable clients reported being with discussing S&I concerns during the first session. It appears that broaching this topic was actually more challenging for us. Since we both have cultural backgrounds where S&I topics are not discussed openly, we found processing our apprehensions and assumptions with each other helped us facilitate the group more effectively. In addition to our shared Marine identity, we also expected our participants to view our role as therapists as a barrier to disclosure. Therefore, vitally important for future providers to address their own hesitations and beliefs around S&I, as this was key to creating a sense of ease and confidence in the group atmosphere.

Further, we understand that our Veteran status may have contributed to clients' initial comfort level, but we credit their continued openness to our collaborative approach. That is, we matched group content directly to the initial needs assessment. We also collaboratively developed group rules and methods of reinforcement. We suggest future groups do the same to ensure group safety and interpersonal respect.

Regarding lessons learned, it is important that providers address their own hesitations and beliefs around S&I, a key to creating ease and confidence in group atmosphere. As our clients expressed significant benefit from participation, we hope that others will be encouraged to broach the subject with confidence and will find the courage to take on this under-treated area of concern among Veter-

ans. Additionally, the interdisciplinary inclusion of guest speakers offered essential expertise and ease of access for Veterans to follow-up with S&I concerns. It is essential to take an active role in collaborative lesson planning with guest speakers to ensure topics match those requested by group members.

We hope others will be inspired by our rewarding experience and look to fill gaps in their treatment programs. We have found this venture to be extremely rewarding as it received an overwhelmingly positive response from everyone involved, and it allowed us to collaborate with a variety of professionals on a project that will help me define our professional identities. Our hope is that our experience will inspire you to be brave and make your mark!

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issues and program development and evaluation. Randall can be reached at nicole.randall@va.gov.

Matthew Golley, M.S. is a doctoral candidate in clinical psychology at Palo Alto University in the Ph.D. program, studying person-centered approaches, mindfulness, rural mental health, and Veteran mental health care issues. His current research focus is on program development/evaluation and understandings of mindfulness.

Review of *Understanding and Healing Emotional Trauma: Conversations With Pioneering Clinicians and Researchers*

Sieff, D. (2014). *Understanding and healing emotional trauma: Conversations with pioneering clinicians and researchers*. New York: Routledge, 247 pages. ISBN-13: 978-0415720847 ISBN-10: 0415720842

Understanding and healing emotional trauma: Conversations with pioneering clinicians and researchers is a compilation of interviews conducted by Daniela Sieff, PhD, a biological anthropologist with interest in psychological dynamics relating to trauma. Sieff explains that in order to heal from emotional trauma, one must identify the impact of these experiences on a client's daily life. At this point, new and healthier ways of relating to the "wounds" left behind can be explored to help clients experience more fulfilling, authentic, and meaningful lives. Sieff suggests that the wisdom embodied in the detailed interviews will help provide perspective to the experience of trauma, which may aid in the healing process for a broad readership. The book is tailored to an audience that has personally experienced and struggled with emotional trauma, mental health professionals who specialize in treating emotional trauma, and parents, teachers, or child care workers who encounter children with histories of emotional trauma.

The first three parts of the book discuss different perspectives on emotional trauma including psychodynamic, neurobiological, and evolutionary theories. The ten interviewees aim to provide insight into a holistic understanding of the effects of trauma to illuminate areas for change and recovery. The concluding section (part 4) consists of Sieff's integration of the information from the ten interviews she conducted.

Chapters 1 through 4 explore the psychodynamic perspectives and psychological dynamics that influence how individuals relate to themselves and others. Psychotherapists contributing to Part 1 include Donald Kalsched, PhD, a clinical psychologist and Jungian analyst in private practice in New Mexico; Bruce Lloyd, a biologist by origin and psychotherapist in the United Kingdom who is influenced by interpersonal, psychodynamic, existential and humanistic perspectives; Tina Strom-

sted, PhD, MFT, BC-DMT, a somatic psychotherapist, board-certified dance/movement therapist and Jungian psychoanalyst in private practice; and Marion Woodman, LLD, DHL, PhD, a Jungian analyst. They draw on professional and personal experience, case studies, myths, poetry, and fairy tales to demonstrate how unconscious forces influenced by emotional trauma manifest in daily life, and importantly, the process through which psychotherapy promotes healing. Individually, they address questions on topics including the unconscious conflicts that emerge as a result of emotional trauma, shame as an inevitable consequence of emotional trauma, historical trauma, the relationship between emotional trauma and addiction, mind-body systems, and recovery.



Christine Valdez, PhD

Chapters 5 through 7 examine the effects of emotional trauma on biological systems and their expression in our lives. Therapist-academics contributing to Part 2 include Ellert Nijenhuis, PhD, a psychotherapist with over 30 years of experience working with profoundly dissociated patients; Allan Schore, PhD, a practicing psychotherapist and interdisciplinary theoretician on affect regulation; and Daniel Siegel, MD, a child psychiatrist and researcher in the field of attachment and a proponent of the role of mindfulness in healing early trauma, and Clinical Professor of Psychiatry at the University of Cali-

fornia, Los Angeles (UCLA) School of Medicine. Again, drawing on professional experience and case studies, as well as literature related to attachment theory, developmental psychology, interpersonal neurobiology, and endocrinology, these interviews address the neurobiological underpinnings of emotional trauma and recovery. The interviews address neurobiological processes underlying dissociation, biological mechanisms that transmit the effects of historical trauma, brain structures implicated in emotional trauma, and the impact of early attachment relationships on shaping the brain, nervous and hormonal systems.

Chapters 8 through 10 illustrate how human evolution has shaped the dynamics of emotional trauma, and how these dynamics manifest today. Academics contributing to Part 3 include James Chisholm, PhD, a developmental psychologist and evolutionary anthropologist, and Professor Emeritus at the University of Western Australia; Sarah Blaffer Hrdy, an anthropologist and primatologist, and Professor Emeritus at the University of California, Davis; and Randolph Nesse, MD, an evolutionary biologist and Professor at Arizona State University. Drawing on studies of hunter-gatherers, Western societies, and non-human primates and other mammals, as well as modern evolutionary theory, attachment theory, and developmental psychology, these interviews illuminate how the world of our distant ancestors left imprints on our minds and bodies. Discussions focus on the evolutionary value of emotions, the continuum of normal to pathological emotional states, sensitivity of infants to caregivers, developmental trajectories of attachment relationships and emotional trauma, evolutionary predispositions toward emotions of shame and self-blame, and the evolutionary perspective on alleviating suffering. Collectively these interviews address trauma in the wider context of our evolved humanity.

The final section, Part 4, integrates the information gleaned from the ten interviews to address why particular types of childhood experience are traumatic and leave lasting imprints on our lives, how emotional trauma creates dynamics that leave us prone to further suf-

fering, and why it is difficult to change trauma dynamics and initiate a positive cycle of change. Collectively, this integrated understanding of trauma can begin to dismantle trauma dynamics and offer “guidance, support, and inspiration” to facilitate the process of lasting and meaningful change.

In this compelling compilation of interviews, Sieff masterfully bridges the gap between clinical practice, theory, and research, providing common ground to inform how trauma affects our lived experiences and how to begin healing. As a biological anthropologist, Sieff offers an intriguing and unique approach to the evolving field of trauma, a subject that requires interdisciplinary thinking. Bringing together leading practitioners, researchers, and scholars from all over the world, this collection of diverse perspectives on trauma offers an in-depth, comprehensive, and holistic view of the effects of emotional trauma on our brain, mind, and body. The thought-provoking, yet accessible content communicates how distinct professional disciplines in the field of trauma may have many connecting threads. Whether you are an expert in the trauma field or are personally struggling with the aftermath of trauma, this book will provide refreshing new material and expand your scientific and emotional understanding of trauma.

Christine Valdez, PhD is a licensed clinical psychologist and Assistant Professor in the psychology department at California State University, Monterey Bay. She received her graduate training with a focus on trauma psychology at Northern Illinois University, and completed her pre-doctoral internship and post-doctoral fellowship in the University of California, San Francisco (UCSF) Clinical Psychology Training Program. At UCSF, she was based at the San Francisco General Hospital/UCSF Trauma Recovery Center, providing empirically supported treatments for victims of crime. Her areas of clinical expertise are in treating interpersonal violence, and her research interests focus on understanding factors that contribute to posttraumatic sequelae and recovery from trauma.

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

Who's Who: Amy Ellis, PhD

1) What is your current occupation?

Currently, I am an Assistant Professor in the Undergraduate Psychology Department at Albizu University. I am also the Co-Director of, and Statistical Design and Research Consultant for, the Trauma Resolution and Integration Program (TRIP) at Nova Southeastern University. In addition, I am the past Associate Editor and the incoming 2017-2020 Internet Editor for the Society for the Advancement of Psychotherapy (APA Division 29) and I also have a small private practice.

2) Where were you educated?

I am a native New Yorker and I received my B.A. in Psychology with an English minor from Hofstra University; from there, I went on to complete my M.A. in General Psychology with a Preclinical Concentration at Adelphi University. I then moved to South Florida and completed my Ph.D. in Clinical Psychology at Nova Southeastern University. My predoctoral internship was at Massachusetts Mental Health Center, an affiliate of Harvard University, and my postdoctoral residency was at the Renfrew Center of Coconut Creek, Florida. My training and education has focused on complex trauma, survivors of sexual abuse, and attachment theory.

3) Why did you choose this field?

I didn't; it chose me! When I was younger (much, much younger) I wanted to be an archaeologist. I was determined to move to Egypt and explore ruins, statues, and tombs. In high school we needed to take a vocational inventory to determine our futures, I suppose, and mine came out with undeniable certainty that I was meant to be in the social services. I cringed at the thought – a psychologist?! Don't they know that I'm supposed to be an archaeologist?! But upon taking an AP Psychology class, I fell in love with the field and I soon realized that digging in the dirt and peering at ancient artifacts is not so different from sitting in the comfort of an office exploring with someone their thoughts, emotions, and life story.

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

I can do so many different and unique things to further my mission of helping people. I love working on a mi-

cro level (e.g., clinical practice) and helping individuals reach their fullest potential, overcome and work through incredible adversities, and then return to a rewarding and fulfilling life. I love working at more macro levels too though, which is where research, writing and publication, and advocacy efforts come into play.

5) What is most frustrating about your work?

The lack of advocacy work that therapists do. I am disheartened that most of us are not explicitly taught about why we should, and how to actually, advocate. I find it frustrating that as therapists we are often taught something else – to be quiet, observe, and take in, but not to speak up. I believe that a large part of our job is to speak up for those who are disenfranchised. It can be as simple as speaking up when we hear a word that is not politically correct or stigmatizing, and it can be as large as marching on Capitol Hill demanding policy and action. Though we are taught tolerance of others, we are also taught intolerance: Intolerance of the status quo, intolerance for the inhumane treatment of any person, and intolerance for those thwarting necessary change. I become frustrated

when we lose sight of that and fail to advocate for the underserved and those who have been silenced.



Amy Ellis, PhD

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

I'd be remiss if I made it sound like I knew the secret formula. I think self-care is an art that we are all striving to achieve. I love to spend time with my husband and two dogs. I read once that doing new and exciting activities increases your perception of a longer life span, so I try to do as many nuanced things as possible!

7) What are your future plans?

Keep doing what I'm doing. I hope to continue my development as an ECP and individual. I hope to continue fostering my passion for working in this field and...to even take a stab at going beyond helping this species and opening up a farm sanctuary.

New Fellow: Amy Ai, PhD, MS, MA, MSW

Amy L. Ai, PhD, MS, MA, MSW is a Professor in the Colleges of Social Work, Arts and Sciences (Psychology), Medicine (Social Medicine and Behavioral Science), Social Science and Public Policy (Pepiper Institute), and Nursing at Florida State University. She is also an affiliate member of the Institute for Successful Longevity. Dr. Ai earned her three masters degrees and her doctorate in Psychology and Social Work at the University of Michigan, and then completed her postdoctoral training with the National Institute of Aging (NIA). Her academic career has focused on interdisciplinary, mixed-methods research on traumatic experiences, existential crises, and positive psychology.

Dr. Ai's work in trauma psychology specifically addresses the role of spirituality in both posttraumatic stress and growth. Her research has covered different types of potentially traumatic events such as open-heart surgery, regional war, terrorist attacks, national disasters, and childhood abuse among minority immigrants. She is a John A. Hartford Geriatric Faculty Scholar and a Fellow of the Association of Psychological Science, American Psychological Association (Divisions 38, 36, and 20), and the Gerontological Society of America. Her work in collective trauma led to awards

as a Senior Fulbright Specialist to both Germany and China. In 2016, she received a prestigious appointment as a Distinguished Chair of the Fulbright Scholar Program on trauma-informed practice and leadership development.



Amy Ai, PhD, MS, MA, MSW

Dr. Ai has been Principal Investigator or Co-Principal Investigator on grants totaling over \$2.5 million, awarded by federal and state governments as well as independent foundations. She is a scientific grant reviewer for national, international, and privately funded agencies including the Department of Defense, Department of Health and Human Services, the National Institutes of Health, the Patient Centered Outcome Research Institute, the United Kingdom Economic and Social Research Council, and the John Templeton Foundation. Dr. Ai has authored over 124 research articles and edited a book. Additionally, Dr. Ai was a Gubernatorial Appointee to former Washington State Governor Christine Gregoire

as a board member of the Washington State Council on Aging, and an At-large Delegate and Representative of Academic Settings to the 2005 White House Conference on Aging. Outside of work she enjoys listening to music, bike riding, swimming, and watching movies.

Division 56 Member News

Compiled by Amy Ellis, PhD & Vanessa Simiola, PsyD

Correction: In the last issue of *TPN* we misspelled one of our member's names. Please note that Lara Barbir, MS successfully defended her dissertation proposal titled, "Posttraumatic Growth in Combat Veterans: The Roles of Mindfulness and Experiential Avoidance."

Phyllis Cohen, PhD, published several papers in the *Journal of Infant, Child, and Adolescent Psychotherapy* (Volume 15, Issue 2) in a special section entitled *Fostering Attachment with Families in the Foster Care System*. The section is about the Building Blocks Program that she has been directing at a NYC mental health agency, The New Alternatives for Children (NAC). This program trains therapists to work dyadically, using video feedback, with birth parents and their children (under 5) who are at-risk or have already been moved to foster

care. In addition, there is a wonderful review by Sara-lea Chazan, of a recent (2014) book that she edited with Mark Sossin and Richard Ruth, *Healing After Parent Loss in Childhood and Adolescence: Therapeutic Interventions and Theoretical Considerations*. This book has wonderful case-based papers by many well-know trauma therapists, including (but not limited to): Vamik Volkan, Diane Ehrensaft, Joy Osofsky, Chandra Ghosh Ippen, Alicia Lieberman, Dan Shechter, Billie Pivnick, Etty Cohen, and many others.

Dennis Debiak, PsyD, is the incoming president of Psychoanalysis (Division 39) for 2017. Dr. Debiak is a faculty member and founding board member at the Institute for Relational Psychoanalysis of Philadelphia. He also serves as an adjunct professor at Widener University.

Michael Eigen, PhD, has published a new book titled *Under the Totem: In Search of a Path*. His book conveys spirit, a sense of the sacred. Freud attempted to get under the totem and explore psychic forces and pressures below the surface. Jung opened further depths in exploration of the sacred. Engagement with a sense of mystery that permeates existence lives in many quarters, including art, music, religion and depth psychologies. The method of this book is fragmentary. Different facets of experience emerge, recede, and reappear, while others enter. The emphasis is on feeling and imaginative reflection. Themes within the book are drawn from therapy sessions and ongoing dialogues with workers who have touched the author, including Bion, Winnicott, Freud, Jung, Klein, Buber, Suzuki, Milner, Wittgenstein, and Wertheimer. The writing grows from love of the psyche, its difficulties and gifts, what we sense as well as the vastness beyond sensing, a love affair ongoing for nearly sixty years of work and acts of shared faith.

<https://karnacology.com/2016/09/07/under-the-totem-in-search-of-a-path-by-michael-eigen/>

Julian Ford, PhD, ABPP, received funding from SAMHSA to serve as Principal Investigator for five years (2016-2021) on two grants in the National Child Traumatic Stress Network: the Center for Trauma Recovery and Juvenile Justice (1 SM080013-01) and the Center for the Treatment of Developmental Trauma Disorders (1 SM080044-01).

Pilar Hernandez-Wolfe, PhD, recently published the Vicarious Resilience Scale (VRS) in *Psychological Trauma: Theory, Research, Practice and Policy*, which will appear online in October. The paper version will be published sometime next year. The other authors of the scale are Kyle Killian, David Engstrom and David Gangsei.

Ani Kalayjian, EdD, organized and chaired a conference at the United Nations in June on Mind-Body-Eco-Spirit Festival, focusing on Sustainable Peace. Over 100 attended, and 10 people graduated as Ambassadors for Meaningfulworld. She also organized and led Meaningfulworld's 11th Humanitarian Mission to Haiti in June. Dr. Kalayjian also participated in several events at the APA Convention in Denver: chaired the International Women's Committee Meeting; organized, chaired and presented a symposium on "Transforming Genocidal Trauma Into Meaning-Making and Forgiveness---Cases From Armenia, Rwanda, Burundi, & Palestine"; chaired the "International Psychology Disaster Mitigation and Violence Prevention" Meeting; spoke on "Ethics: Give It What You've Got!—Tutoring Psychologists in Use of Self for Social Good"; and organized and chaired a symposium on "International Humanitarian Aid and Social Justice---Challenges and Lessons Learned". Dr. Kalayjian was elected the Chairperson for the Psychology

Coalition at the United Nations and was elected a Board Member for the International Division (Division 52) of Psychology at American Psychological Association June 2016. Dr. Kalayjian recently published her poem on "I am a Syrian Refugee."

Heather Littleton, PhD, co-authored a chapter with Julia Dodd, PhD, called "Psychosocial functioning within shooting-affected communities: Individual and community-level factors," in *The Wiley Handbook of the Psychology of Mass Shootings*, which will be available this month. This comprehensive book on mass shootings is edited by Laura C. Wilson, PhD, and covers such areas as the psychology of perpetrators, the role of the media in mass shootings, adjustment post-shooting at the individual and community level, as well as interventions for shooting-affected individuals. Other contributors include Edna Foa, Elana Newman, Carol North, Betty Pfefferbaum, and David Valentiner

Nancy Maguire, PsyD, co-authored the chapter "Sex, Gender and Psychological Assessment: Integrating Principle and Feminist Ethics" with Patria Alvelo and Linda Knauss in *The Handbook of Gender and Sexuality in Psychological Assessment*, edited by Virginia M. Brander and Joni L. Mihura

Walter Erich Penk, PhD, recently co-edited *The Handbook of Psychosocial Interventions for Veterans and Service Members* along with Nathan D. Ainspan and Craig J. Bryan.

Ilene Serlin, PhD, BC-DMT, would like to invite Division 56 members to join her at an upcoming conference to work with Syrian refugees in Jordan. The conference, "Transgenerational Trauma: Communal Wounds and Victim Identities" will be held October 26-29, 2017. She has worked with Steve Olweean, the coordinator, and his work is deeply humanitarian. Dr. Serlin will participate in the conference and the clinic, and will help train staff and volunteers to use movement (she is both a psychologist and dance therapist) for trauma. Interested individuals are encouraged to contact Steve Olweean (SOlweean@aol.com) directly or Dr. Serlin (iserlin@iserlin.com) directly. Dr. Serlin is also working on an invited proposal from Routledge for a book on *Whole Person Approaches to Working with Trauma*. She welcomes chapters from anyone working from a model that is collaborative and holistic and invites people to contact her directly if interested.

Robert D. Stolorow, PhD recently published an article titled "Using Heidegger," to be published in the *Journal of the American Psychoanalytic Association*, 64(4). The article explains how Heidegger's existential philosophy provides valuable philosophical tools for grasping the existential significance of emotional trauma.



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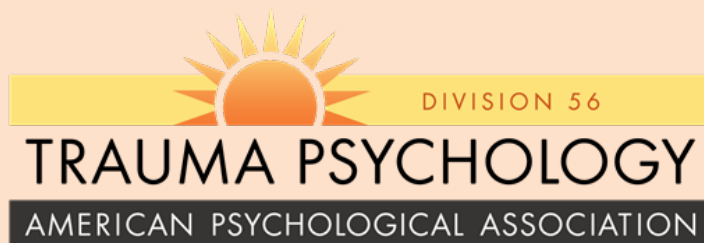
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