FALL 2018 | VOL. 13, NO. 3

DIVISION 56

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

NEWS

Presidential Voice

Diane Castillo, PhD

Greetings Division 56 members. In this note, I have two topics of focus. First, I wish to congratulate you all for a wonderful convention at APA in San Francisco. As Program Chair, Dr. Bryann DeBeer did a wonderful job of organizing our outstanding Division programming and making it all public as the Chair of the Social Media Committee. I wish to acknowledge her efforts and the efforts of the many others which contributed to a great convention. Bryann expanded our social media efforts by posting a live stream of the Expert Panel on the Evolution of PTSD by Drs. Keane, Schnurr, Resick, and Fairbank and the Presidential Address on our Facebook page. The recordings have been viewed close to 800 and 400 times, respectively, allowing those who did not attend to view these talks. Additionally, she tweeted many Division 56 presentations in both regular and hospitality suite programming. All this media attention allows us to be more responsive to our members and to those outside our division, highlighting the outstanding work we do as trauma psychologists. We are working with our President-Elect, Sylvia Marrotta-Walters, and her Program Chair, Delishia Pittman, to further extend what we've accomplished.

Diane Castillo, PhD

And now I wish to express my thoughts beyond our Division and APA into the politics facing us in these troubling times. I have read the many posts on our listserv and seen the proactive efforts of our members regarding the experience of Dr. Ford and the treatment she received when testifying on her sexual assault as a teen. I applaud your efforts. For over 25 years I treated female Veterans who experienced sexual trauma in their youth and as adults. Historically, before we acknowledged the psychological effects of trauma in the diagnosis of PTSD, people often viewed trauma with a "blame the victim" mentality. While this blaming occurred in Vietnam Veterans, it was also obvious in women who experienced sexual assault. I am disheartened that as far as we have progressed as a society, it takes so little to regress into old ways of thinking. It reflects how many more people in our society have not changed. I see this lack of change as our challenge as trauma psychologists. How can we continue to educate the people around us and our world with the message that trauma survivors are not to blame? We are in a unique position to educate our peers and our nation. This is therefore, my call to action to each of you. I realize the work you do every day as trauma psychology therapists, administrators, and researchers is terribly important and active. We need to do more. Please think about what you can do. Can you add one more action to your daily activities? It is clear that we as trauma psychologists will continue to lead the world in educating people in how to better understand and conceptualize how trauma affects everyone. This is our responsibility.

-Diane

Elected Positions by the Division

President
Diane Castillo, Ph.D.
Email: diane.castillo@va.gov

President-Elect
Sylvia Marotta, Ph.D., ABPP
Email: syl@gwu.edu

Past-President
Elizabeth Carll, Ph.D.
Email: ecarll@optonline.net

Secretary (3 years, renewable for one term)
Kathleen Kendall-Tackett, Ph.D., IBCLC
Email: kkendallt@gmail.com

Treasurer (3 years, renewable for one term)
Lisa Rocchio, Ph.D., Chair
Email: lrocchio@drlisarocchio.com

Council Representatives from Division 56 to APA (3 years, renewable for one consecutive term)
Dawn Hughes, Ph.D., ABPP
Email: info@drdawnhughes.com

Steven N. Gold, Ph.D.
Email: gold@nova.edu

Early Career Psychologist Representative to Division 56 EC (2-year term, renewable for one consecutive term)
Christine Valdez, Ph.D.
Email: Christine.Valdez@ucsf.edu

Members-at-Large to Division 56 EC (3 years, renewable for one consecutive term)
Divya Kanaan, Ph.D.
Email: divya.kannan@vanderbilt.edu

Robyn Gobin, Ph.D.
Email: info@robyngobin.com

Carlos Cuevas, Ph.D.
Email: c.cuevas@neu.edu

Professional Affiliate Representative (2-year term, renewable for one consecutive term)
Sherry Wilcox, Ph.D.
Email: slwilcox@usc.edu

Student Representative (2-year term, renewable for one consecutive term)
Leah Kaylor, M.A., Chair
Email: kaylorle@slu.edu

Position Selected by President and Search Committee:

Journal Editor, Chief
Kathleen Kendall-Tackett, Ph.D., IBCLC
Email: kkendallt@gmail.com

Positions Selected by Journal Editor-in-Chief

Journal Editors, Associates (1 year with auto renew, not past 2020)

Tyson D Bailey, Psy.D.
Email: tdbaileypsyd@gmail.com

Diane Castillo, Ph.D.
Email: diane.castillo@va.gov

Diane Elmore Borbon, Ph.D, M.P.H.
Email: diane.elmore@duke.edu

Paul Frewen, Ph.D.
Email: pfrewen@uwo.ca

Sylvia Marotta, Ph.D., ABPP, Associate Editor
Email: syl@gwu.edu

Sandra Mattar, Psy.D., Associate Editor
Email: sm26@stmarys-ca.edu

Zhen Cong, Ph.D., Associate Editor for Statistics
Email: zhen.cong@ttu.edu

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

Awards Committee
Kathleen Kendall-Tackett, Ph.D., IBCLC, Co-Chair
Email: kkendallt@gmail.com

Sandra Mattar, Psy.D., Co-Chair
Email: Bita.Ghafoori@csulb.edu

Convention Program Committee
Bryann DeBeer, Ph.D., Program Co-Chair
Email: Bryann.debeer@va.gov

Delishia Pittman., Ph.D., Program Co-Chair
Email: dmpittman@email.gwu.edu

Robyn Gobin, Ph.D., Suite Programming Chair
Email: Email: info@robyngobin.com

Disaster Relief Committee
Gilbert Reyes, Ph.D., Chair
Email: greyes@fielding.edu

Diversity and Multicultural Committee
Divya Kanaan, Ph.D., Co-Chair
Email: divya.kannan@vanderbilt.edu

Bekh Bradley-Davino, Ph.D., Co-Chair
Email: rbradl2@emory.edu

Early Career Psychologist Committee
Christine Valdez, PhD, Chair
Email: Christine.Valdez@ucsf.edu

Education and Training Committee
Carlos A. Cuevas, Ph.D., Co-Chair
Email: c.cuevas@northeastern.edu

Terri Weaver, Ph.D., Co-Chair
Email: weavert@slu.edu

Webinar Committee
George Rhoades, Ph.D., Chair
Email: dr.grhoades@gmail.com

Fellows Committee
Laurie Anne Pearlman, Ph.D., Chair
Email: lpearlmanphd@comcast.net

Finance Committee
Lisa Rocchio, Ph.D., Chair
Email: lrocchio@drlisarocchio.com

International Committee
Elizabeth Carll, Ph.D., Chair
Email: ecarll@optonline.net

Liaison Committee
Jack Tsai, Ph.D., Chair
Email: Jack.Tsai@yale.edu

Membership Committee
Erin Hambrick, Ph.D., Co-Chair
Email: hambricke@umkc.edu

Josh Rinker, Psy.D. Co-Chair

Email: josh.rinker@gmail.com

Nominations and Elections Committee
Elizabeth Carll, Ph.D., Chair
Email: ecarll@optonline.net

Policy Committee
Diane Elmore, Ph.D., MPH, Chair
Email: diane.elmore@duke.edu

Practice Committee
Paul Frewen, Ph.D., C.Psych, Chair
Email: pfrewen@uwo.ca

Publications Committee
Jack Tsai, Ph.D., Chair
Email: Jack.Tsai@yale.edu

Science Committee
Constance Dalenberg, Ph.D., Chair
Email: cdalenberg2@alliant.edu

Social Media Committee
Bryann DeBeer, Ph.D., Chair
Email: Bryann.debeer@va.gov

Special Interest Groups Coordinator (3-year term)
Seda Terzyan, Ph.D., Chair
Email: sterzyan@gmail.com

Student Affairs Committee
Leah Kaylor, M.A., Chair
Email: kaylorle@slu.edu

Other Individual Appointments:

Listserv Manager (appointment by the President and confirmed by EC, renewable yearly)
Olivia Scott
Email: oscott@apa.org

Monograph Series Co-Editors
Anne P. DePrince, Ph.D.
Email: adeprinc@du.edu

Ann Chu, Ph.D.
Email: annchu09@gmail.com

Newsletter Editor (appointed by the President and confirmed by EC for 3-year term, renewable for one term)
Jonathan Cleveland, Ph.D.
Email: jonathan.cleveland@uc.edu

Web Editor (appointed by the President and confirmed by EC for 3-year term, renewable for two terms) www.apatraumadivision.org
Tyson Bailey, Psy.D.
Email: tdbaileypsyd@gmail.com

Task Forces (President selects)

APA Refugee Mental Health Resource Network Steering Committee
Elizabeth Carll, Ph.D., Chair
Email: ecarll@optonline.net

Carl Auerbach, Ph.D., Vice Chair
Email: cauerbac@gmail.com

Betsy Gard, Ph.D., Vice Chair
Email: drbetsy5151@comcast.net

Developing Web-Based Trauma Psychology Resources Task Force
Vanessa Simiola, Co-Chair
Email: Vanessa.simiola@yale.edu

Amy Ellis, Ph.D., Co-Chair
Email: amyellisphd@gmail.com

Addressing Trauma in General Medical Health Settings Task Force
Terri deRoon-Cassini, Ph.D., Chair
Email: tcassini@mcw.edu

Meeting the Needs of Veterans in the Community Task Force
Sonya B. Norman, Ph.D., Co-Chair
Email: snorman@ucsd.edu

Jessica L. Hamblen, Ph.D., Co-Chair
Email: jessica.hamblen@dartmouth.edu

Child Trauma Task Force
Julian D. Ford, Ph.D., A.B.P.P., Co-Chair
Email: jford@uchc.edu

Carla Stover, Ph.D., Co-Chair
Email: carlastover@usf.edu

Practice and Education Task Force
Bethany Brand, Ph.D., Co-Chair
Email: bbrand@towson.edu

Janna A. Henning, Psy.D., Co-Chair
Email: jhenning@adler.edu

Complex Trauma Task Force
Christine Courtois, Ph.D., Chair
Email: Ccourtois@aol.com

Facilitating Male Trauma Survivors' Meaningful Involvement in Health Research Task Force
Christopher Anderson, Co-Chair
Email: canderson@malesurvivor.org

Joan M. Cook, Ph.D., Co-Chair
Email: Joan.Cook@yale.edu

Expanding and Integrating

Jonathan Cleveland, PhD
Editor-in-Chief

Welcome to the fall issue of *Trauma Psychology News (TPN)*. In this issue, we bring you two new sections. The Military Psychology section contains a discussion of a specialized intervention called Impact of Killing (IOK), by Drs. Shira Maguen and Kristine Burkman. In the first appearance of the Philosophical/Psychoanalytic section, you will find a thought-provoking article/book-review by Dr. Robert Stolorow on what he terms "apocalyptic anxiety."

The pages that follow contain a number of other compelling pieces, including a feature on posttraumatic growth in Haiti. A bit later in the issue, the Multicultural and Diversity section offers an important discussion of research related to the victimization of transgender individuals. You will also find two strong student spotlight articles, an International section update, as well as coverage of Division-related awards from this past summer. Finally, be sure to swing by the Who's Who to learn a bit more about our excellent associate editor, Dr. Wyatt Evans.

TPN belongs to all Division 56 members. Please be encouraged to send any feedback or suggestions you may have to *traumapsychologynews@gmail.com*. We welcome and value your perspective.

Best regards,
-Jon

Jonathan Cleveland, Ph.D.
Editor-in-Chief

Announcement: Spring Special Section: Dissociation

If you are a researcher or clinician working in the area of dissociation, please consider contributing a case study, discussion of research, theoretical article, or opinion piece for inclusion in our upcoming special issue. The call for submissions will go out in January, but we are happy to receive your work at any time.

Please send all submissions to: *traumapsychologynews@gmail.com*

IN THIS ISSUE

Announcing Winners & Brief Biographies of Division 56 Awards

Amy E. Ellis, Ph.D. & Vanessa Simiola, Psy.D.

On Friday, August 10th, the Trauma Psychology Division held its Social Hour and Awards Ceremony to honor the various members whose work has been pivotal in the field of trauma. Award winners were either nominated by colleagues or self-nominated, and reviewed based on established criteria for appropriateness for the particular award, quality of work, significance of contributions, and commitment to the field of trauma psychology.

Award for Outstanding Contributions to Practice in Trauma Psychology: Richard B. Gartner, Ph.D.

Dr. Gartner has been a member of Division 56 since its inception. A graduate of Haverford College and Columbia University and a Fellow of Division 39 (Psychoanalysis), he is best known for his work with men with histories of sexual abuse. In 1994 he was a Co-Founder of MaleSurvivor (malesurvivor.org) and has remained active in the organization, serving on its Board of Directors for seven years and President for two years; he is currently Chair of its Advisory Board. Dr. Gartner is the author of *Betrayed as Boys: Psychodynamic*

Richard B. Gartner

Treatment of Sexually Abused Men (1999), and *Beyond Betrayal: Taking Charge of Your Life after Boyhood Sexual Abuse* (2005). He has been quoted widely in the media about male sexual victimization and serves on the editorial boards of three journals. He is also Supervisor and Consultant at the Trauma Treatment Center of the Manhattan Institute for Psychoanalysis; supervised in the clinical psychology program at Columbia University for 20 years; and serves on the Advisory Board of the Leadership Council on Child Abuse and Interpersonal Violence. Dr. Gartner has also recently published three books: *Trauma and Countertrauma, Resilience and Counterresilience, Understanding the Sexual Betrayal of Boys and Men,* and *Healing Sexually Abused Men and Boys.*

Award for Outstanding Contributions to the Science of Trauma Psychology: Karen J. Saywitz, Ph.D.

Drs. Bette Bottoms and Gail Goodman nominated Dr. Saywitz, along with six of her former students and four esteemed colleagues. Dr. Saywitz was a Professor of Psychiatry and Behavioral Sciences in the UCLA Department of Psychiatry, where she conducted research on child maltreatment, child forensic interviewing,

Sue Hobbes

foster care, and child mental health, and where she taught doctoral and medical students about trauma and children's mental health, developmental psychology, and children and law. Dr. Saywitz co-received the very first federal grant on children's eyewitness testimony. A resulting early article on children's memory for stressful genital examinations (Saywitz et al., 1991) is now a classic in the field (cited nearly 500 times according to Google Scholar). Dr. Saywitz, a former president of Division 37, received the APA Division 37 Nicholas Hobbs Award for Child Advocacy and Lifetime Advocacy Award. She also won the Research Career Achievement Award from the American Professional Society on the Abuse of Children, Child Abuse Professional of the Year Award for pioneering research from the California Consortium to Prevent Child Abuse, the Distinguished Service Award from the California Professional Society on the Abuse of Children, and the Award for Research and Service Excellence from the Long Beach Child Trauma Council. Dr. Sue Hobbes accepted the award on Dr. Saywitz' behalf.

Award for Outstanding Service to the Field of Trauma Psychology

Mark C. Russell, Ph.D., ABPP, ABCCAP

Dr. Mark Russell was nominated by Dr. Charles Figley. Dr. Russell served 10-years as a U.S. Marine. He earned a bachelor's and master's degree in psychology from Chapman College and left active- duty to pursue his doctorate at Pacific Graduate School of Psychology (PGSP). He became an intern in the Navy and became the first military intern selected for a post-doctoral fellowship. Dr. Russell is a dual Board certified licensed

Mark C. Russell

psychologist in clinical psychology and child and adolescent clinical psychology with nearly three decades immersed as a scientist-practitioner and public policy advocate. He is the establishing director of Antioch University's Institute of War Stress Injury, Recovery, and Social Justice dedicated to ending mental health stigma and other preventable causes of a generational cycle of wartime behavioral health crises. Dr. Russell's ground-breaking research on war trauma is featured in the film *Thank You for Your Service* at the 2015 NYC Documentary Film Festival. Dr. Russell has previously received the 2006 Washington State Psychological Association Distinguished Psychologist Award; the 2005 Meritorious Service Medal awarded by President Bush, and has been a Fellow of the Tulane Traumatology Institute since 2015. He is a highly published trauma psychologist who has been an effective leader in the field of trauma psychology within military mental health.

Award for Media Contributions to the Field of Trauma Psychology

Jennifer J. Freyd, Ph.D.

Dr. Freyd was nominated by Dr. Carolyn Allard. Dr. Freyd is a Professor of Psychology at the University of Oregon and a Fellow, 2018-19, at the Center for

Jennifer J. Freyd

Advanced Study in the Behavioral Sciences at Stanford University. She received her PhD in Psychology from Stanford University. Dr. Freyd is a widely published and nationally-renowned scholar whose work focuses on studies of betrayal trauma, institutional betrayal, and sexual violence, as well as minority discrimination, gender and sexual orientation, trauma and disclosures of abuse. The author or coauthor of over 200 articles and op-eds, Dr. Freyd is also the author of the Harvard Press award-winning book *Betrayal Trauma: The Logic of Forgetting Childhood Abuse.* Her most recent book *Blind to Betrayal,* co-authored with Pamela J. Birrell, was published with seven additional translations. In 2014, Dr. Freyd has received numerous awards including being named a John Simon Guggenheim Fellow, an Erskine Fellow at The University of Canterbury in New Zealand, and a Fellow of the American Association for the Advancement of Science. In April 2016, Dr. Freyd was awarded the Lifetime Achievement Award from the International Society for the Study of Trauma & Dissociation. Dr. Freyd currently serves as the Editor of *The Journal of Trauma & Dissociation.* Additionally, in 2011, Division 56 presented Dr. Freyd with the Award for Outstanding Contributions to Science in Trauma Psychology.

Early Career Award for Racial/Ethnic Minority Psychologist in Trauma Psychology: Angela Narayan, Ph.D.

Dr. Angela Narayan is an assistant professor in the clinical child psychology doctoral program at the University of Denver and a licensed psychologist in Colorado. She received her Ph.D. in clinical child psychology from the Institute of Child Development at the University of Minnesota and completed her predoctoral internship and post-doctoral fellowship at the University of California, San Francisco. Dr. Narayan's research examines intergenerational pathways of psychopathology and resilience in

Angela Narayan

socioeconomically, ethnically, and culturally-diverse populations with a focus on how the pregnancy period is a transformative opportunity to buffer the transmission of risk. She is currently working to understand how benevolent childhood experiences and childhood adversity in pregnant women and expecting fathers affect their transition to parenthood, romantic and co-parenting relationships, and the health and wellbeing of their offspring.

There were four additional awards, however the nominees were not able to attend in person. They are:

- **Award for Outstanding Dissertation in the Field of Trauma Psychology:** Megan K. Maas, Ph.D.
- **Award for Outstanding Contribution to Trauma Psychology by an Early Career Psychologist:** Rebecca K. Blais, Ph.D.
- **Award for Lifetime Achievement in the Field of Trauma Psychology:** Christine Courtois, Ph.D., ABPP
- **Presidential Award for Outstanding Contribution to the Field of Trauma Psychology:** Terrence M. Keane, Ph.D.

Division 56 Listservs

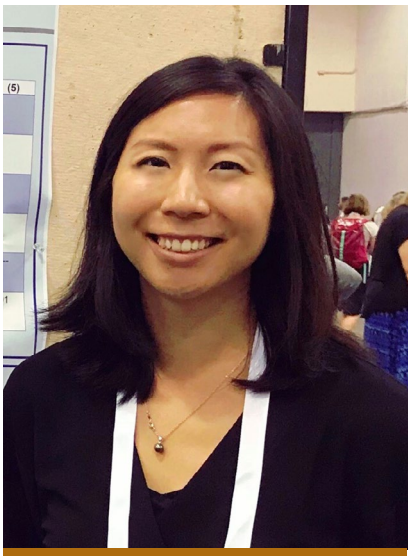
Anyone who belongs to Division 56 is added to **div56announce@lists.apa.org** listserv, for news and announcements. Join any of the following lists by sending an email to listserv@lists.apa.org and typing the following in the body of the note: subscribe name (where name is the part before the @, for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

div56@lists.apa.org	*for discussion among members*
div56childtrauma@lists.apa.org	*for child trauma topics*
div56dissociation@lists.apa.org	*for post-traumatic dissociative mechanisms development*
div56ecpn@lists.apa.org	*for early career psychologists networking*
div56stu@lists.apa.org	*for student forum*

APA 2018 Travel Awardees

Christine Valdez, Ph.D.

Division 56 is in its second year supporting two scholarships (1 student member and 1 ECP member) of $500 each to assist with travel expenses associated with attending the annual APA Convention. These scholarships are intended to increase Division 56 student and ECP member participation at the APA Convention. We had a number of outstanding applicants. This year's student and ECP award recipients were Sharon Lee and Dr. Wyatt Evans, respectively.



Sharon Lee

Sharon Lee is a fifth-year Ph.D. student in clinical psychology at the University of Connecticut where she works under the advisement of Dr. Crystal Park. Her clinical and research interests focus on the impact of trauma and stress on physical health, with an emphasis on cardiovascular behavioral medicine.

"I am incredibly grateful to Division 56 for their generous Student Travel Award, which supported my attendance at the 2018 APA Convention. At Convention, I presented a talk titled "Impact of Psychological Trauma on Appraisals of Current Stressors and Cardiovascular Health" as part of a Division 56-sponsored symposium about the potential mechanisms linking trauma and biopsychosocial well-being. Keeping in line with my interest in trauma, stress and health, I also presented a poster on the relationships between discrimination, health behaviors, and physical health symptoms in a longitudinal sample of undergraduates. In addition to engaging in dialogue with others about my research and develop my scientific communication skills, Convention allowed me to expand my breadth of knowledge about trauma and health through exposure to other researchers' work. From talks and poster sessions, I conversed with presenters about their work related to the interplay of trauma, culture and identity, and its effects on health. Finally, the 2018 Convention was particularly significant for me this year because I was able to attend several talks and events related to clinical internship, which I will be applying for this fall. Overall, I had an amazing time at the 2018 APA Convention thanks to the support of Division 56!"

Wyatt Evans

Wyatt Evans, PhD is a clinical psychologist and trauma psychology fellow in the Department of Psychiatry at the University of Texas Health Science Center San Antonio. He currently serves as a research therapist for the STRONG STAR Consortium and Consortium to Alleviate PTSD and a research associate with the National Center for PTSD. He received his PhD in Clinical Psychology from Palo Alto University in 2017, completing clinical training at the VA Palo Alto Health Care System and his pre-doctoral internship at the Michael E. DeBakey VA Medical Center in Houston before accepting his current position at Fort Hood, TX. Dr. Evans specializes in combat and operational stress injuries in active duty service members and veterans. Among other leadership positions, he currently serves as the Associate Editor of Division 56's *Trauma Psychology News*.

"I am extremely grateful to Division 56 and the Travel Award Committee for selecting me as this year's ECP travel award recipient! Attending Convention this year was incredibly valuable to me for several reasons. First, Division 56's *Trauma Psychology News* recently underwent a change in the editorial staff and I moved from Editorial Assistant to Associate Editor. Attending Convention allowed the Editor-in-Chief and I to discuss the future of the publication and to solicit contributions from some amazing researchers, clinicians, and students who presented in San Francisco. Stay tuned for some exciting things to come!

Additionally, this was my first APA Convention since 2013, when I attended during my first year of graduate school. It was wonderful to expand my professional network as a new ECP in the field of trauma psychology and to (re)connect with colleagues and collaborators, especially those in Division 56. I look forward to next year's convention, to hopefully presenting some exciting new research findings, and to continuing to connect and collaborate with current and prospective Division 56 members!"

Impact of Killing (IOK): Expanding our Framework to Help Veterans Heal from War

Kristine Burkman, PhD. & Shira Maguen, PhD

Currently, there are only two evidence-based psychotherapies (EBPs) for PTSD endorsed by the Veterans Health Administration (VHA), Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE). Randomized controlled trials (RCTs) for PTSD have traditionally focused on a reduction in PTSD symptoms, which are often anchored to traumatic events involving direct life threat or witnessing of death or injury. However, there is a range of post-combat sequelae that veterans confront, and a recent meta-analysis found that, despite receiving EBPs for PTSD, 60-72% of combat veterans continue to meet diagnostic criteria for PTSD, and their functioning remains measurably compromised (Steenkamp, Litz, Hoge, & Marmar, 2015). For some, it is not the fear associated with direct threat or witnessing horrific acts, it is *doing violence (such as killing)* that generates feelings of guilt, anger, and spiritual distress that increases risk of suicidal ideation and attempts, alcohol abuse, and other functional difficulties even after controlling for general combat exposure (Bryan, Bryan, Roberge, Leifker, & Rozek, 2017, Kopacz, Hoffmire, Morley, & Vance, 2015, Purcell et al., 2016). Growing evidence in the moral injury literature suggests that we need to expand our framework beyond the traditional fear-based traumatic response that is well addressed in existing EBPs for PTSD, to more fully respond to the wounds of war (Maguen & Burkman, 2013).

Kristine Burkman

Shira Maguen

The Impact of Killing (IOK) treatment reflects the culmination of nearly ten years of our research on the topic of killing in war and moral injury among combat veterans. In addition to quantitative research revealing that killing in war was associated with negative mental health outcomes (Maguen et al., 2009; 2012; 2013), we conducted focus groups with veterans of all eras to discuss their experiences with killing, the ways in which killing continued to impact their lives post-deployment, and how killing has or has not been addressed in existing PTSD treatments (Purcell, Koenig, Bosch, & Maguen, 2016) with an eye towards strengthening treatment in this area. The Killing Cognition Scale (KCS), a self-report measure assessing beliefs about killing in war, highlights prominent themes revealed in these focus groups (e.g., guilt/shame, self-betrayal of morality, loss of spirituality, condemned self, etc.). The KCS is a vital part of the IOK treatment, administered in the first session to identify areas of potential cognitive distortions as well as areas requiring acceptance, loss, and forgiveness work.

Treatment Description

IOK consists of ten sessions of weekly, individual psychotherapy lasting 60-90 minutes with a therapist who has specialized training in trauma. Ideally, veterans will have either completed an EBP for PTSD, or have engaged in some form of psychotherapy prior to engaging in IOK, given the brevity in which we review the cognitive-behavioral model and the intensity of emotion associated with moral injury. The treatment starts with completing the KCS and reviewing ways past work was helpful, as well as anticipating challenges of successfully completing the IOK protocol (see Table 1). The treatment then aims to destigmatize and further tailor interventions by reviewing common reactions to killing and other morally injurious acts. Subsequent sessions focus on parsing out killing-related beliefs that can be challenged versus those that will be earmarked for acceptance, forgiveness, and amends work. Acceptance work further identifies the impact moral injury has had on veterans' lives and acknowledges both wounds inflicted upon veterans as well as wounds veterans have inflicted on themselves and others. The sessions on forgiveness explore how veterans define forgiveness, which often reveals numerous barriers to engaging in forgiveness of self and others. Our goal is to identify these barriers and collaboratively design assignments (both written and behaviorally based) that allow veterans to work towards greater self-forgiveness and forgiveness of others. Finally, we identify ways veterans can honor

their morality by developing an action, or amends plan intended to carry the veteran forward throughout their life and encourage greater connection (e.g., time with loved ones, community service, time in nature, spiritual community) and improved overall functioning.

Distortions vs. Acceptance: Exposure (both in vivo and imaginal) and Socratic questioning with trauma reactions are powerful interventions that can challenge erroneous relationships made in the aftermath of traumatic events. These approaches offer much

Table 1: Impact of Killing (IOK) Treatment Session-by-Session Outline

Session	Description	Content
1	**Pre-Treatment Evaluation**	Assessment, past work, barriers to treatment, and coping skills
2	**Common Responses to Killing-Part 1**	Physiology, instinctual decisions, and initial reactions
3	**Common Responses to Killing-Part 2**	Emotions, behaviors, beliefs
4	**Cognitive Behavior Therapy (CBT) Elements**	CBT framework, meaning of killing, killing cognitions
5	**Becoming Unstuck**	Maladaptive killing cognitions (cont.), behavioral activation, intro to acceptance
6	**Acceptance and Moral Injury**	Acceptance (cont.), role of betrayal in moral injury, related sequalae
7	**Forgiveness-Part 1**	Defining forgiveness and self-forgiveness, barriers to self-forgiveness, and intro to forgiveness plan
8	**Forgiveness-Part 2**	Areas of forgiveness, function of self-forgiveness, forgiveness letters
9	**Taking the Next Step**	Forgiveness letters (cont.), making amends, connection to others
10	**Maintaining Gains**	Healing as a process, plan to continue work

Key Differences

IOK is designed to complement existing EBPs for PTSD, such as PE and CPT. We believe that many veterans will benefit from these treatments, and yet for some, offering a different frame might allow for further healing of moral injury that is related but not equivalent to PTSD. Below, we outline core differences of IOK from existing EBPs for PTSD.

needed clarity around issues of context, responsibility, probability, and a wish for the event to never have occurred in the first place. However, for some veterans, it is not the distortions, but rather the clarity of our human capacity for destruction and cruelty that haunts them, and they may need more than what EBPs for PTSD offer. IOK makes this distinction explicit with veterans, acknowledging the need for acceptance and grief work around things they did or did not do that

cannot be changed and violated deeply held beliefs about right and wrong. Acceptance work in sessions 5-6 often involves recognition of the sequalae that followed the moral injurious event(s) (e.g., withdrawal from loved ones, substance abuse, suicide attempts, etc.) and builds compassion for the emotions and beliefs that drove those behaviors (i.e., self-loathing, spiritual unmooring, disgust with humanity) while also taking responsibility for the impact of moral injury on themselves and others. IOK is explicit in the process of separating out beliefs that can be challenged to reveal a more balanced truth from those beliefs that need to be acknowledged as a painful reality and earmarked for a forgiveness and amends framework.

Direct language: Focus groups with combat veterans of multiple eras revealed the importance of using the word "killing" in our assessment and treatment of combat experiences (Purcell et al., 2016). Some veterans reported that they had been in trauma treatment for years, even decades, and had never been asked directly about killing in war which made them think 1) killing was not an appropriate topic for treatment, and/or 2) clinicians might judge them if they volunteered that information. Veterans further revealed by using euphemisms for killing such as "taking lives" or "eliminating targets," providers indirectly communicate that killing (even in war) is still unacceptable, as it cannot be named. In our interviews with trauma providers, there was unanimous agreement that topic of killing was an appropriate and important issue in treatment. However, providers also shared that they were either explicitly taught *not* to ask about killing experiences, given veterans' report of insensitive and voyeuristic interactions with civilians, or they felt at a loss of how to broach the subject (Burkman, Purcell, & Maguen, *in press*).

We have found two approaches helpful in initiating a conversation about killing. First, we believe that embedding questions about killing or other morally injurious events in the context of general combat exposure is a good way to destigmatize the topic and recognize that killing and engaging in acts that some may find crossed a personally held moral line is part of what we ask of our servicemembers when we send them to war. Like assessment with other traumatic events, initial information gathering may not be the time to ask about details of specific events, but to *not* ask even a perfunctory "were you exposed to this?" may communicate that the topic is not suitable for treatment and places the onus on the veteran to self-disclose experiences of killing or other morally injurious events. Second, the development of the KCS allowed a shared language for providers and veterans to tackle this challenging topic. We inform veterans that the items on the KCS were generated by combat veterans of multiple eras and that some items may resonate while others may not apply. Again, this is a way for the provider to initiate the conversation about various ways veterans may respond to and make sense of killing while allowing for a wide range of responses.

Forgiveness: Another important difference in IOK is our use of forgiveness as a conceptual anchor. We are routinely asked by colleagues why we don't just stick with the concept of acceptance, since so many veterans have a strong, negative reaction to the word forgiveness. Acceptance is a critical component of forgiveness—acceptance of what occurred, acceptance of human and for some, spiritual (i.e., deity) fallibility, and self-acceptance around falling short or betraying one's of moral self. Acceptance is an essential precursor to forgiveness, and particularly self-forgiveness. Self-forgiveness, which we focus on most in IOK, is an active process often rooted in veterans' spiritual and/or moral upbringing, which is an area many providers express discomfort in addressing or report they have been trained to avoid as a topic of psychotherapy (Aist, 2012). However, exploring veteran's moral and spiritual development is vital to understanding personal and cultural factors that influenced the moral injury and often reluctance to pursue self-forgiveness. Providers must invite veterans into these often-fraught conversations to learn what disturbs them so much about the concept of forgiveness and especially self-forgiveness.

Acknowledging barriers to self-forgiveness is key. For example, some veterans believe self-forgiveness equates to condoning actions they felt were wrong, or "letting themselves off the hook" for something they shouldn't have done, which might allow them to it again. Other veterans feel forgiveness (of self or others) is not possible without justice; therefore, they serve as their own judge, jury, and at the extreme, executioner. IOK does not promise agreement on a universal definition of forgiveness, rather, it explores the concept to allow veterans to define it for themselves and take specific actions to better understand what is needed to move towards forgiveness of self and others. The forgiveness letters often reveal powerful themes of remorse, loss, grief, and despair as well as wishes for how the veteran and humanity could be and what they hold most sacred. We argue that encouraging a conversation about why forgiveness is or is not possible allows providers to identify key areas of the wound and collaboratively build a plan (i.e., Forgiveness Plan, sessions 7-9) with veterans to acknowledge the wrong done, learn from it, grieve it, and commit to acting in accordance with one's morality (i.e., Amends Plan, sessions 9-10) moving forward, targeting improved functioning and quality of life. Veterans who completed the pilot trial shared that the forgiveness assignments were by far the most challenging in the treatment and yet also the most powerful (Purcell et al., 2018).

Catalyst vs. Resolution: We do not anticipate that moral injury will be resolved within a matter of weeks or even months, and we do not view it as a condition with

symptoms that wax and wane (like PTSD). Rather, we view IOK as a springboard for continued work outside the therapeutic relationship and assert that healing is an ongoing process requiring persistent, active participation on the part of the veteran to accept, forgive, and move forward in a way that honors their sense of morality. In recognition of the weighty, existential nature of the questions veterans struggle with (e.g., human beings' capacity for good and evil, karmic retribution, redemption, etc.), it is critical that therapists using IOK offer space to lay out all the pieces contributing to the conflict without getting stuck in a rhetorical loop or concede to a premature conclusion that ultimately rings hollow. It is in the naming of specific barriers to forgiveness of oneself (e.g., not wanting to condone actions, fear it could happen again, desire for justice of those harmed/killed, belief only God can grant forgiveness) that veterans reveal their core values, often shaped by their moral and spiritual beliefs. We believe that by reflecting these concerns and the values they bely and collaboratively developing a plan that identifies specific tasks, rituals, or participation in communities that veterans can *actively pursue*, we can help move the needle in the daunting task of moral repair.

Conclusion

Emerging research on moral injury continues to highlight the need to expand our treatment options for veterans presenting with a range of problems. We believe that IOK offers a unique but complementary approach to existing EBPs for PTSD that addresses these problems. When asked, trauma providers in a large VA medical center reported they felt IOK could be easily incorporated into their clinics and fit nicely with a phase-based model of care (Burkman et al., *in press*). Further research on the effectiveness of IOK across multiple clinical sites will be helpful in assessing generalizability.

References

Aist, C. S. (2012). The recovery of religious and spiritual significance in American psychiatry. *Journal of Religion and Health*, *51*, 615-629.

Bryan, C. J., Bryan, A. O., Roberge, E., Leifker, F. R., & Rozek, D. C. (2017). Moral Injury, posttraumatic stress disorder, and suicidal behavior among national guard personnel. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. http://dx.doi.org/10.1037/tra0000290

Burkman, K., Purcell, N., & Maguen, S. (*in press)* Provider perspectives on a novel moral injury treatment for veterans: Initial assessment of acceptability and feasibility of the Impact of Killing treatment materials. *Journal of Clinical Psychology.*

Kopacz, M. S., Hoffmire, C. A., Morley, S. W., & Vance, C. G. (2015). Using a spiritual distress scale to assess suicide risk in veterans: An exploratory study. *Pastoral Psychology*, *64*(3), 381-390.

Maguen, S. & Burkman, K. (2013). Combat-related killing: Expanding evidence-based treatments for PTSD. *Cognitive & Behavioral Practice*, *20*(4), 476- 479.

Maguen, S., Burkman, K., Madden, E., Dinh, J., Bosch, J., Keyser, J., …Neylan, T. C. (2017). Impact of killing in war: A randomized, controlled pilot trial. *Journal of Clinical Psychology, 73*(9), 997-1012.

Maguen, S., Madden, E., Bosch, J., Galatzer-Levy, I., Knight, S. J., Litz, B. T., …McCaslin, S. E. (2013). Killing and latent classes of PTSD symptoms in Iraq and Afghanistan veterans. *Journal of Affect Disorders, 145*(3), 344-8. doi: 10.1016/j.jad.2012.08.021

Maguen, S., Metzler, T. J., Bosch, J., Marmar, C. R., Knight, S. J., & Neylan, T. C. (2012). Killing in combat may be independently associated with suicidal ideation. *Depression & Anxiety, 29*(11), 918–923.

Maguen, S., Metzler, T. J., Litz, B. T., Seal, K. H., Knight, S. J., & Marmar, C. R. (2009). The impact of killing in war on mental health symptoms and related functioning. *Journal of Traumatic Stress*, *22*(5), 435-443.

Purcell, N., Burkman, K., Keyser, J., Fucella, P., & Maguen, S. (2018). Healing from moral injury: A qualitative evaluation of the *Impact of Killing* treatment for combat veterans. *Journal of Aggression, Maltreatment & Trauma*, *27*(6), 645-673.

Purcell, N. J., Koenig, C. J., Bosch, J., & Maguen, S. (2016). Veterans' perspectives on the psychosocial impact of killing in war. *The Counseling Psychologist, 44*(7), 1062–1099.

Steenkamp, M. M., Litz, B. T., Hoge, C. W., & Marmar, C. R. (2015). Psychotherapy for military-related PTSD: A review of randomized clinical trials. *JAMA, 314*(5), 489-500.

Kristine Burkman, PhD: *Dr. Burkman is an Assistant Clinical Professor in in the Department of Psychiatry, UCSF School of Medicine and a staff psychologist in the Substance Use and PTSD (SUPT) Clinic at the San Francisco VA Health Care System (SFVAHCS). She provides direct clinical service and supervision for predoctoral and postdoctoral trainees in the assessment and treatment of co-occurring trauma and substance abuse with a focus on complex and developmental trauma. Dr. Burkman served as a study therapist on the Impact of Killing (IOK) pilot trial and played an integral role in developing the IOK manual and related training materials.*

Shira Maguen, PhD: *Dr. Maguen is a Professor in the Department of Psychiatry, UCSF, Mental Health Director of the Post-9/11 Integrated Care Clinic and Staff Psychologist on the PTSD Clinical Team at the San Francisco VA Health Care System. Her research interests fall under the umbrella of PTSD, moral injury, and suicide, including veteran risk and resilience factors. She is the author of over 100 peer-reviewed publications. Dr. Maguen received two VA grants examining the impact of killing in war and moral injury. Her work resulted in the development of a killing-related cognition scale and a novel treatment to address moral injury, called Impact of Killing.*

Death, Afterlife, and Doomsday Scenario: Why Do We Evade the Extreme Dangers of Climate Change? (A Review of Samuel Scheffler's Death and the Afterlife)

Robert D. Stolorow, Ph.D.

In a blog post of a year ago examining the motivations underlying the pervasive evasion of the catastrophic consequences of climate change, I included this personal vignette: "More than three decades ago I took my young son to a planetarium show at the New York Museum of Natural History. During that show it was predicted that a billion years from now the sun will become a "red giant" that will engulf and destroy our entire solar system. This prospect filled me with intense horror. Why would a catastrophe predicted to occur in a billion years evoke horror in me?"

Robert D. Stolorow

I explained that the "horror that I felt was an extreme form of existential anxiety—the anxiety that accompanies our recognition that, as finite human beings, we are constantly threatened by impending possibilities of trauma, harm, disease, death, and loss, which can occur at any time. But what I felt at the planetarium show was more than that, because the sun's becoming an engulfing red giant represents not just the destruction of individual human beings but of human civilization itself.... The destruction of human civilization would also terminate the historical process—the sense of human history stretching along from the distant past to an open future—through which we make sense out of our individual existences. I want to call the horror that announces such a possibility *apocalyptic anxiety*. Apocalyptic anxiety anticipates the collapse of all meaningfulness. And it is from apocalyptic anxiety that we turn away when we deny the extreme perils of climate change."

Samuel Scheffler, in his timely, thought-provoking, and *Angst*-evoking book, *Death and the Afterlife*, provides detailed and sophisticated philosophical arguments that can lend substance to the impressionistic claims made in my blog post. The book is concerned not with a personal afterlife but with a *collective afterlife*—the survival of human life on earth for an indefinite period of time after one's own death. Making use of two thought experiments, the *doomsday scenario* (knowing that the earth will be completely destroyed by a giant asteroid 30 years after one's own death) and the *infertility scenario* (knowing that all human beings have become infertile and that the human race faces imminent extinction), Scheffler argues persuasively that the taking for granted of such a collective afterlife underpins our valuing or caring about our various activities, projects, and involvements, and that the absence of such a pre-reflective conviction would seriously erode such valuing and mattering. He summarizes his arguments as follows:

I have argued that the survival of people after our deaths matters greatly to us ... because it is a condition of many other things that now matter to us continuing to do so. In some very significant respects, we actually care more about the survival of others after our deaths than we do about the existence of a personal afterlife, and the imminent disappearance of the human race would have a more corrosive effect on our ability to lead ... 'value-laden lives' than does the actual prospect of our own death.... In this respect ... the survival of humanity matters more to each of us ... even than our own survival (pp. 80-81).

In language similar to some of mine in my previous blog post, Scheffler writes that a meaningful human life "relies on an implicit understanding of such a life as itself occupying a place in an ongoing human history, in a temporally extended chain of lives and generations" (p. 43), "a history that transcends the history of any individual" (p. 59). In the absence of a collective afterlife, meaningfulness collapses, leading to pervasive apathy and *ennui*.

In arguments too intricate and technical to summarize here, Scheffler applies his *afterlife conjecture* to a number of issues in philosophical value theory—the limits of individualism and egoism in constituting values; the conservative, nonexperiential, and nonconsequentialist dimensions of valuing; and the complex relations between valuing and temporality, especially the future.

I, in contrast, will apply the afterlife conjecture to an understanding of the pervasive evasion of the very real possibility of the doomsday scenario posed by the specter

of climate change. Scheffler himself alludes to such evasion when he notes that there "are actually things we can do to promote the survival and flourishing of humanity after our deaths, such as taking action to solve the problems of climate change" (p. 78), and that it is "unreasonable" that we fail to do more, but he does not explain this failure.

An explanation of the evasion perhaps requires a shift from a philosophical to a psychoanalytic perspective emphasizing the unbearable emotions that would accompany a facing-up to a doomsday scenario with its collapse of meaning. It is from the *horror* of the doomsday scenario posed by climate change that the minimizers, scoffers, and ridiculers turn away. Ironically, in turning away from the extreme dangers of climate change, we contribute to the coming to be of the horrifying catastrophe we are evading. We must face up to our apocalyptic anxiety before it is too late for the survival of future generations. Such facing-up requires that we open a far-reaching emotional dialogue in which the *Angst* can be collectively held and borne.

References

Scheffler, S. (2013). *Death and the Afterlife*. Oxford, UK: Oxford University Press.

Stolorow, R. D. (2007). *Trauma and Human Existence: Autobiographical, Psychoanalytic, and and Philosophical Reflections*. New York: Routledge.

Robert D. Stolorow *is a Founding Faculty Member at the Institute of Contemporary Psychoanalysis, Los Angeles, and at the Institute for the Psychoanalytic Study of Subjectivity, New York. Absorbed for more than four decades in the project of rethinking psychoanalysis as a form of phenomenological inquiry, he is the author of World, Affectivity, Trauma: Heidegger and Post-Cartesian Psychoanalysis (Routledge, 2011) and Trauma and Human Existence: Autobiographical, Psychoanalytic, and Philosophical Reflections (Routledge, 2007) and coauthor of nine other books. He received his Ph.D. in Clinical Psychology from Harvard in 1970 and his Ph.D. in Philosophy from the University of California at Riverside in 2007.*

Division 1, Society for General Psychology, Awards Call

Division 1, The Society for General Psychology, seeks nominations for its 2019 awards:

- The William James Book Award honors a recent book that best serves to further the goals of the division by providing an outstanding example of a coherent strategy for integrating diverse subfields of psychology and related disciplines.
- The Ernest R. Hilgard Award for a Career Contribution to General Psychology recognizes an individual who has made significant contributions to the division's ideals and mission.
- The George A. Miller Award for an Outstanding Recent Article in General Psychology acknowledges a recent paper that contributes to the division's ideals and mission.

The above award winners will each give an invited address at the 2019 APA annual convention. Upon completion of their address, each will receive a certificate, a medal, and $1,500.

The Division also welcomes nominations for the Arthur W. Staats Lecture for Unifying Psychology, a talk to be presented at the 2020 APA Annual Convention. This award honors an individual who has made contributions toward integrating the diverse subfields for the integration of psychology. Upon completion of their talk, the winner will receive a certificate, a medal, and $1,000. The award is sponsored by the American Psychological Foundation and coordinated by Division 1.

Finally, the Anne Anastasi General Psychology Graduate Student Award will recognize two outstanding students (one in the first two years of graduate work and one who has completed at least two years of graduate work already) based on their vitae, research plan, and a supporting letter from their advisor. The winner will receive a $300 prize.

For more information about each award, including where to send nominations, visithttp://www.apadivisions.org/division-1/awards/index.aspx. Nominations and supporting materials are due February 15, 2019. Self-nominations are welcome.

Understanding Posttraumatic Growth in Haiti

M. Ainelle Mercado, Marie Valsaint, Skultip (Jill) Sirikantraporn,Grant J. Rich, & Wismick Jean-Charles

Despite being the first nation in the world created as a result of a successful slave revolt and also the first independent nation in Latin America and the Caribbean in 1804, Haiti in recent years has faced numerous problems, including poverty, corruption, unemployment, and most recently, the devastation brought upon by the 2010 earthquake. The 7.0 magnitude earthquake, centered near the capital Port-au-Prince, was one of the most traumatic events that Haiti has ever faced. An estimated 200,000 people died, and hundreds of thousands more were displaced. Psychological effects of the earthquake included posttraumatic stress symptoms and depressive symptoms (Burnett Jr. & Helm Jr., 2013; Blanc, Rahill, Laconi, & Mouchenik, 2016). Historically, while research has focused on examining the negative results of traumatic events, such as natural disasters, recent efforts have shifted the focus to examining the positive aspects, or rather the strengths, that enable individuals and communities to thrive. This article examines posttraumatic growth (PTG) in Haitian survivors of the earthquake and its implications for trauma recovery among adult Haitians.

M. Ainelle Mercado

Posttraumatic Growth

PTG is a term coined by researchers Tedeschi and Calhoun (1996) and is defined as the positive psychological changes that occur as a result of experiencing trauma (Tedeschi & Calhoun, 1996). Research indicates that after a traumatic event, it becomes possible for individuals to go through a transformative experience that gives them the adaptive ability to improve their perception or opinion of themselves and others (Calhoun, Cann, & Tedeschi, 2010). Furthermore, the experience of positive growth occurs in five distinct life domains: personal strength, new possibilities, relating to others, appreciation of life, and spiritual change (Tedeschi & Calhoun, 2004).

Marie Valsaint

Recent research that investigated PTG in Haiti after the earthquake utilized a mixed methods study, including a grounded theory approach, and found themes related to adult Haitians' maturing perspectives on the roles of external support persons or sources, as well as internal strengths, appreciation for life, perceived happiness, and an increased role of religion (Mercado et al., 2018; Rich, Sirikantraporn, & Jean-Charles, 2018). These studies found that changes in interpersonal relations occurred through the increased desire to help people in need, as well as a greater focus on being "kinder to people in life." Indeed, this finding is consistent with previous research, which indicates that individuals that report PTG often express having an increased sense of compassion for others (Lindstron, Cann, Calhoun, & Tedeschi, 2013). Hence, they experience more meaningful relationships with other people (Lindstron, Cann, Calhoun, & Tedeschi, 2013; Prati & Pietrantoni, 2009).

Research also indicates that individuals that report PTG become more aware of their own personal strengths and gain a greater appreciation of life (Janoff-Bulman, 2004; Tedeschi & Calhoun, 2004). For Haitian survivors of the earthquake, personal strength is gained through self-acceptance, overcoming adversities, and the understanding that one can continue to move forward in life despite traumatic experiences (Mercado et al., 2018). With personal strength comes greater appreciation of life, as survivors become more grateful and thankful for what they currently have in their lives. Indeed, they report "not taking life for granted" and "living life in the moment to the fullest" (Mercado et al., 2018). Moreover, for Haitian survivors of the earthquake, a greater appreciation of life contributes to their happiness. In fact, some expressed that due to their experience of trauma, they gained a greater sense of peace and freedom, which contributes significantly to their ability to enjoy life and live life happily. (Mercado et al., 2018).

Furthermore, individuals that report PTG report experiencing spiritual growth, which contributes to a greater sense of purpose and meaning in life (Shaw, Joseph, & Linley, 2007; Tedeschi & Calhoun, 2004). For Haitian survivors of the earthquake, the

role of religion is reported to significantly contribute to trauma recovery (Mercado et al., 2018; O'Grady et al, 2012). Indeed, survivors reported that recovery is gained through the belief in God and through prayers. Additionally, recovery is believed to be strengthened through the understanding that religion or spirituality allows one to not feel "alone" in the experience of great adversity (Mercado et al., 2018).

Skultip (Jill) Sirikantraporn

Implications for Trauma Recovery

Among factors that contribute to PTG, religious and spiritual beliefs have been shown to play a prominent role in reaction to traumatic events (Wilson & Boden, 2008). Indeed, religion and spirituality can provide an extensive variety of potential benefits including a sense of meaning and purpose in life, a sense of harmony and inner peace, and faith that one is being cared for and looked after by a higher power (Gall, Kristjansson, Charbonneau, & Florack, 2009).

In Haiti, religion – which includes Catholicism, Vodou, and Protestantism – plays a vital role in all areas of life. It not only gives Haitians a sense of purpose in life, but it also provides a sense of utility, comfort, belonging, structure, and discipline (Corten, 2000; Hurbon, 2004). Vodou, in particular, is often regarded as a health care system among those that practice it. Indeed, it promotes healing practices, disease prevention, and personal well-being (Augustin, 1999). Vodou also provides information on how to promote, prevent, and treat health problems, through disease theories, treatment interventions, and behavioral prescriptions that are consistent with other widespread explanatory models (Vornarx, 2008). Aside from Vodou, many Haitians also practice Catholicism or Protestantism, which help promote emotional and psychological well-being (Kirmayer, 2010). In fact, over half of Haitians are Catholic, about one-fourth to one-third are Protestant, and a number of Haitians combine some elements of Vodou with their practice of Christianity.

Grant J. Rich

For Haitians, religion can help diminish despair and create hope in difficult circumstances. As such, spiritual leaders can be allies to mental health professionals working to help individuals recover from trauma, as they are able to gain the confidence of communities more quickly than mental health professionals that are coming into the community. When mental health professionals engage with key spiritual leaders, the collaborative relationship that is built can be utilized to improve community responses to disasters and therefore assist in trauma recovery (Aten et al., 2014). Indeed, when this type of collaborative relationship has been established, spiritual leaders are more willing to act as facilitators and refer community members for mental health treatment as well as encourage them to adhere to recommended treatments (Aten, 2004). Engaging spiritual leaders also provides mental health professionals the opportunity to gain important knowledge from them regarding cultural contexts as well as the specific dynamics of members of their faith community (O'Grady et al., 2012). This could subsequently allow mental health professionals and spiritual leaders alike to create trauma recovery approaches that are both community-specific and culturally sensitive (Aten et al., 2014; O'Grady et al., 2012). Once mental health professionals have established relationships with spiritual leaders and their communities, they will have a greater opportunity to provide therapeutic services, including interventions that could facilitate the process of PTG, to survivors.

References

Aten, J.D. (2004). Improving understanding and collaboration between campus ministers and college counseling center personnel. *Journal of College Counseling, 7*, 90-96.

Aten, J.D., O'Grady, K.A., Milstein, G., Boan, D., & Schruba, A. (2014). Spiritually oriented disaster psychology. *Spirituality in Clinical Practice, 1* (1), 20-28.

Augustin, J. (1999). *Le vodou libérateur: Et si le vodou était une valeur!--*. Montréal: Tanboula.

Blanc, J., Rahill, G.J., Laconi, S., & Mouchenik, Y. (2016). Religious belief, PTSD, depression and resilience in survivors of the 2010 Haiti earthquake. *Journal of Affective Disorders, 190,* 697-703.

Burnett Jr., H.J. & Helm Jr., H.W. (2013). Relationship between posttraumatic stress disorder, resilience, and religious orientation and practices among university student earthquake survivors in Haiti. *International Journal of Emergency Mental Health and Human Resilience, 15* (2), 97-104.

Calhoun, L. G., Cann, A., & Tedeschi, R. G. (2010). The posttraumatic growth model: Sociocultural considerations. In T. Weiss & R. Berger (Eds.), *Posttraumatic growth and culturally competent practice: Lessons learned from around the globe* (pp. 1-14). Hoboken, NJ, US: John Wiley & Sons Inc.

Corten, A. (2000). *Diabolisation et Mal Politique. Haïti: misère, religion et politique.* Montréal: les Éditions CIDIHCA.

Gall, T. L., Kristjansson, E., Charbonneau, C., & Florack, P. (2009). A longitudinal study on the role of spirituality in response to the diagnosis and treatment of breast cancer. *Journal of Behavioral Medicine, 32*, 174–186. doi:10.1007/s10865-008-9182-3

Hurbon, L. (2004). *Religions et lien social: l'Église et l'État moderne en Haïti*. Paris, Éditions du Cerf.

Janoff-Bulman, R. (2004). Posttraumatic growth: Three explanatory models. *Psychological Inquiry, 15* (1), 30-34.

Kirmayer, L. J. (2010). Culture and mental health in Haiti: A literature review. *Department of Mental Health and Substance Abuse*. http://www.who.int/mental_health/emergencies/culture_mental_health_haiti_eng. pdf

Lindstrom, C.M., Cann, A., Calhoun, L.G., & Tedeschi, R.G. (2013). The relationship of core belief challenge, rumination, disclosure, and sociocultural elements to posttraumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy, 5* (1), 50-55.

Luthar, S.S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work.

Mercado, M.A., Seward, D., Valsaint, M., Sirikantraporn, S., Rich, G., & Jean-Charles, W. (2018, August). *Posttraumatic growth in Haiti: A mixed methods study*. Poster session presented at the meeting of the American Psychological Association, San Francisco, CA.

O'Grady, K.A., Rollison, D.G., Hanna, T.S., Schreiber-Pan, H., Ruiz, M.A. (2012). Earthquake in Haiti: Relationship with the sacred in times of trauma. *Journal of Psychology & Theology, 40* (4), 289-301.

Prati, G. & Pietrantoni, L. (2009). Optimism, social support, and coping strategies as factors contributing to PTG: A meta-analysis. *Journal of Loss and Trauma, 14*, 364–388.

Rich, G. J., Sirikantraporn, S., & Jean-Charles, W. (2018). The concept of Posttraumatic growth in an adult sample from Port-au-Prince, Haiti: A mixed-methods study. In Rich, G.J., & Sirikantraporn, S. (Eds.), *Human Strengths and Resilience: Cross-cultural, developmental, and international perspectives* (pp. 21-38). Maryland: Lexington Books.

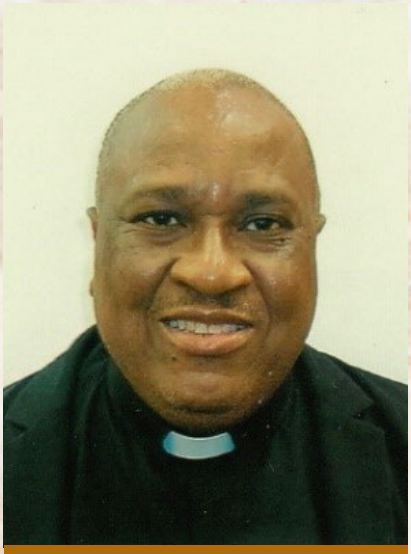
Shaw, A., Joseph, S., Linley, P.A. (2007). Religion, spirituality, and posttraumatic growth: A systematic review. *Mental Health, Religion & Culture, 8* (1), 1-11.

Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*, 455-471.

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*, 1-18.

Vonarx, N. (2008). Le Vodou haïtien comme système de soins, nouvelle lecture. In: J. Hainard, P. Mathez & O. Schinz (eds.), *Vodou* (pp. 177-197), Geneva: Infolio, Musée d'ethnographie de Genève.

Wilson, J. T. & Boden, J. M. (2008). The effects of personality, social support and religiosity on post- traumatic growth. *Australasian Journal of Disaster and Trauma Studies, 2008* (1), 1–19.



Wismick Jean-Charles

M. Ainelle Mercado, MA *is currently a 3rd year graduate student at the California School of Professional Psychology at Alliant International University in San Diego, working towards her doctorate in Clinical Psychology. She received her B.S. in Neuroscience at the University of California Los Angeles and her M.A. in Counseling Psychology with a focus on Marriage and Family Therapy at National University. Her research interests are in trauma and posttraumatic growth. Her clinical experience includes conducting psychological assessments and working in community mental health settings, residential treatment facilities, and public schools with children, adolescents, and families that experienced trauma.*

Marie Valsaint, M.A., *earned her B.A. in Psychology and Sociology at Florida Atlantic University. Marie is currently a graduate student at Alliant International University (CSPP), San Diego with the goal of becoming a multicultural (clinical) psychologist. She is currently working on developing a website (haitiansthrive.com) dedicated to providing mental health resources for the Haitian community. The website will also address some of the barriers (e.g. stigma) which may impact accessing treatment. Ms. Valsaint is also a member of the Haitian Bridge Alliance, Inc., which is dedicated to supporting Haitian Immigrants in the state of California in becoming self-sufficient.*

Skultip (Jill) Sirikantraporn, PsyD *is a licensed psychologist in California and New York with research interests in trauma and resilience in the context of cross-cultural and international psychology. She obtained her doctoral degree in clinical psychology from Antioch University Seattle. She is a founding faculty at Fulbright University Vietnam. She has taught multicultural competence development, qualitative methods of research, and intellectual assessment. Jill has a passion for working with individuals from various cultural groups, honoring their unique ways of healing and growing, especially after major life crises. She is a registered yoga instructor and uses holistic, mind-body integration as part of therapy and self-healing.*

Grant J. Rich, PhD *received his Ph.D. in Psychology: Human Development from the University of Chicago. He is senior editor of Pathfinders in International Psychology (2015) and has three additional coedited books for 2017-2018: "Internationalizing the Teaching of Psychology", "Human Strengths and Resilience: Developmental, Cross-Cultural, and International Perspectives", and "Teaching Psychology Around the World". A Fellow of the American Psychological Association, the Society for the Teaching of Psychology, and the Society for Media Psychology and Technology, Dr. Rich has taught at institutions around the globe, recently in Alaska, Cambodia, and India. He is a National Board Member of the NCBTMB.*

Wismick Jean-Charles, PhD, *Haitian priest, is the current vice president of the University of Notre Dame, in Haiti. He received his doctorate in psychology from Fordham University, New York.*

An Overview of Transgender Sexual Victimization

Shawn Fraine

While the term "gender" is often equated with the construct of biological sex, it actually refers to the socially constructed roles, behaviors, activities, and attributions that are the traditional norm for one's assigned biological sex. Most current western societies only reference two genders (male and female); however, many societies since antiquity have had more (e.g., hijras, two-spirit). The term "transgender" is used as an umbrella term for those whose assigned biological sex is different from their gender identity. Alternately, the term "cisgender" commonly refers to a person whose gender identity and biological sex match.

Shawn Fraine

Since its earliest conceptualization, the construct now known as gender dysphoria has been controversial. Early descriptions in the Diagnostic and Statistical Manual of Mental Disorders, third edition (DSM-III) stated that gender identity disorder "almost always" developed as a result of a problematic relationship with a parent or resulted from "extreme" or "prolonged" closeness to one's mother during infancy. While much has changed since DSM-III, these historical conceptualizations of etiology have, in large part, resulted in a negative view of the field of psychology in the transgender community, making research with this community difficult. The little research that exists almost exclusively relies on local convenience samples, many of which use only those who have already transitioned or want to transition "full-time" (e.g., Testa et al., 2012). Yet, as our understanding of gender identity has evolved, so too has the concept of transgenderism.

Prevalence and Negative Effects of Sexual Violence

Sexual Victimization. Transgender sexual victimization has only recently been attended to in the literature, which is very limited in scope. However, the research that does exist suggests that this population has a higher rate of victimization than the general population (Testa et al., 2012). These authors suggested prevalence rates of 24% for transgender women and 35% for transgender men. These are higher than sexual victimization statistics reported for the general public by Black et al. (2010) in their Centers for Disease Control and Prevention (CDC) report, which suggests prevalence rates of 18% and 1% for women and men, respectively.

Our recent study, including participants who identified as transgender (so as to be as inclusive as possible), found that transgender persons were 2.3 times more likely to be sexually victimized than their cisgender peers and 1.2 times more likely than cisgender lesbian, gay, and bisexual (LGB) people (Fraine, Pawlow, Pomerantz, & Pettibone, 2018). These same data revealed that 87% of transgender participants reported a sexual victimization event, significantly higher than the 74% reported by their cisgender and 84% of LGB peers.

Transgender survivors of sexual victimization overwhelmingly report that they believe their victimization was due to their gender identity or expression (Testa et al., 2012). In fact, it has been reported that simply exhibiting gender nonconforming behaviors is a risk factor for violence against transgender individuals (Lombardi, Wilchins, Priessing, & Malouf, 2001). Not only are transgender individuals more likely to experience victimization, but transgender survivors are also more likely to suffer from mental health issues correlated with victimization experiences like drug and alcohol abuse (Testa et al., 2012). Previous research has suggested that transgender survivors of sexual victimization are also more likely to attempt suicide than those who have not experience sexual victimization (Xavier, Bobbin, Singer, & Budd, 2005; Clements-Nolle, Marx, & Katz, 2006).

Revictimization. Another well-documented issue that plagues many survivors of sexual victimization is revictimization. Multiple victimizations compound the risk for mental health issues such as Posttraumatic Stress Disorder (PTSD) and dissociation, and a recent meta-analysis of the general population suggests that 48% of survivors go on to be revictimized (Walker, Freud, Ellis, Fraine, & Wilson, 2017).

Our study was, to our knowledge, the first to explore revictimization in the transgender population, finding that transgender persons were 1.6 times more likely to experience revictimization than their cisgender peers and were only slightly less likely than LGB persons. Our data suggest that 82% of transgender victims were be revictimized. This rate was significantly higher than the 68% reported by cisgender participants in the study.

Mental Health and Help-Seeking.

Greater risk for mental illness has been well established within the broader LGBT community. Comorbidity, for example, has been shown to be 4 times higher in the LGB population (Spengler & Ægisdóttir, 2015). However, this is does NOT suggest that being LGBT *causes* mental illness; instead, it suggests that issues like prejudice, discrimination, and internalized stigma due to our heterosexist society play a vital role in the mental health of sexual and gender minorities (Meyer, 2003).

Sexual minorities have been shown to seek help from mental health providers at higher rates than heterosexuals, even if there is no current presenting issue (Rutter et al., 2016). However, those who experience sexual violence tend to seek help at lower rates (Thompson, Sitterle, Clay, & Kingree, 2007). Conjointly, recent research has found that sexual minorities who have experienced sexual violence sought help at significantly lower rates than heterosexuals who have also experienced sexual violence (Richardson, Armstrong, Hines, & Reed, 2015).

Our study also looked at attitudes toward psychological services. We compared cisgender, sexual minority, and transgender survivors and non-survivors of sexual trauma. While past research suggested that transgender and LGB survivors view psychological services less favorably, this was not the case in our sample. In fact, while the attitudes of non-survivors were still more favorable overall, transgender survivor attitudes were not significantly lower than non-survivors and were not significantly different from cisgender survivor attitudes. This suggests that transgender survivors may potentially be viewing psychological services more positively than they had in the past and/or that they may be currently more likely to seek help after their victimization than was historically the case.

Resilience.

Resilience theory argues that resilience is a combination of both personal attributes and the complex transactions with a person in their environment (Gitterman & Germain, 2008). As such, resilience has been widely accepted as a protective factor against mental illness. While the literature has been growing over the last decade, we have been unable to locate any research to date that has compared resilience across transgender, sexual minorities, and cisgender groups.

We found that transgender participants, regardless of victimization status, scored significantly lower on a popular measure of resilience, suggesting that transgender individuals may be less resilient than their cisgender peers. Meyer's minority stress theory should be kept in mind; internalized stigma, social prejudice, and discrimination may hinder a person's resilience. With all of this associated distress, it may be difficult for transgender survivors of sexual victimization to remain hopeful and optimistic, factors which are associated with resilience (Kwon, 2013).

Conclusion

Our data paint both a bleak and a hopeful picture for members of the transgender community. On the one-hand, sexual victimization rates in this sample were astonishingly high, higher than in previous reports. To our knowledge, we were the first to report revictimization data for this population and those numbers were exceedingly high as well. Finally, this community may be less resilient in the face of trauma than their cisgender counterparts. This could be, at least in part, due to other stressors that transgender survivors face daily. However, on the positive side, our data suggest that this population may be more open to seeking help for mental health issues related to sexual victimization than they have been in the past.

The "me too" movement has drawn considerable attention to sexual victimization in the past year and recent political events have caused many survivors to relive their traumatic experience. While we continue to explore sexual victimization in an attempt to help our clients and participants, it is critical that gender minorities be included in the conversation.

References

Black, M. C., Basile, K. C. Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., Chen, J., & Stevens, M. R. (2010). *The national intimate partner and sexual violence survey (NISVS): 2010 summary report.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Clements-Nolle, K., Marx, R., & Katz, M. (2006). Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization. *Journal of Homosexuality, 51*, 53 – 69.

Fraine, S. F., Pawlow, L. C., Pomerantz, A. M., & Pettibone, J. C. (2018). Sexual Victimization of the Transgender Population (Master's thesis). Retrieved from ProQuest Disstertations and Theses database. (UMI No. 10750694)

Gitterman, A., & Germain, C. B. (2008). *The life model of social work practice* (3rd ed.). New York, NY: Columbia University Press.

Kwon, P. (2013). Resilience in lesbian, gay, bisexual individuals. *Personality and Social Psychology Review, 17*(4), 371 – 383.

Lombardi, E. L., Wilchins, R. A., Priessing, D., & Malouf, D. (2001). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality, 42,* 89 – 101.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129,* 674 – 697.

Richardson, H. B., Armstrong, J. L., Hines, D. A., & Reed, K. M. P. (2015). Sexual violence and help-seeking among LGBQ and heterosexual college students. *Partner Abuse, 6*(1), 29 – 46.

Rutter, T. M., Flentje, A., Dilley, J. W., Barakat, S., Liu, N. H., Gross, M. S., Muñoz, R. F., & Leykin, Y. (2016). Sexual orientation and treatment-seeking for depression in a multilingual worldwide sample. *Journal of Affective Disorders, 206,* 87 – 93.

Spengler, E. S. & Ægisdóttir, S. (2015). Psychological help-seeking attitudes and intentions of lesbian, gay, and bisexual individuals: The roles of sexual minority identity and perceived counselor sexual prejudice. *Psychology of Sexual Orientation and Gender Diversity,*

2(4), 482 – 491.
Testa, R. J., Sciacca, L. M., Wang, F., Hendricks, M. L., Goldblum, P., Bradford, J., & Bongar, B. (2012). Effects of violence on transgender people. *Professional Psychology: Research and Practice, 43*(5), 452 – 459.
Thompson, M., Sitterle, D., Clay, G., & Kingree, J. (2007). Reasons for not reporting victimizations to the police: Do they vary for physical and sexual incidents? *Journal of American College Health, 55*(5), 277 – 282.
Walker, H. E., Freud, J. S., Ellis, R. A., Fraine, S. F., & Wilson, L. C. (2017). The prevalence of sexual revictimization: A meta-analytic review. *Trauma, Violence, & Abuse,* 1 – 14.
Xavier, J., Bobbin, M., Singer, B., & Budd, E. (2005). A needs assessment of transgendered people of color living in Washington, D. C. *International Journal of Transgenderism, 8,* 31 – 47.

Shawn Fraine *recently earned an M.A. in Clinical Psychology from Southern Illinois University Edwardsville and is now the project coordinator of the SPAN lab at Washington University in St Louis. His research interests include sexual health and relationships within the LGBTQ+ community, sexual trauma, and factors that contribute to the prevention of revictimization. Shawn will be applying to Ph.D. programs for Fall 2019.*

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

Listservs: 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.

International Committee Report

Elizabeth Carll, PhD & Vincenzo Teran, PsyD

Zeynep Sagir: Recipient of the Division 56 Travel Assistance Stipend for the 2018 APA Convention

To encourage international participation, the APA Trauma Psychology Division provides an annual travel stipend to attend the APA Convention for international students who are citizens of developing countries and enrolled in a graduate psychology program in their home country, or enrolled in a graduate psychology program in the U.S., and who will be presenting a trauma related poster, paper, or participating in a symposium or panel at the APA Convention. Please note that international students from developing countries are not required to be a member of any Division or APA to apply for the stipend, as this is an opportunity for them to become familiar with APA, if not already involved.

The travel assistance stipend consists of $1000 for travel expenses to the APA Convention and a one-year free membership in the Trauma Psychology Division. The stipend is intended as partial support and matching grants or additional support from other institutions and organizations are encouraged.

The recipient of the 2018 Travel Award was Zeynep Sagir, a doctoral student at the University of Istanbul, Turkey. She presented her creative study focusing on Syrian refugees who fled to Turkey at the APA Convention in San Francisco. The study examined acculturation, mental health, coping, and forgiveness versus retaliation. She was also part of a symposium at this year's convention.

Elizabeth Carll

Vincenzo Teran

Zeynep Sagir

In her study, Sagir surveyed 2000 Syrian refugees in Turkey who had fled the Syrian war 0-6 years ago. Measures included: (a) psychological states (depression, coping, life satisfaction, somatization, religiousness), (b) trauma (being bombed, shot, raped, tortured, imprisoned, beaten), (c) strategy to acculturate to Turkey by integrating, assimilating, separating, or marginalizing, (d) proclivity to forgive the perpetrators, vs. favoring retaliation. In-depth qualitative interviews of 100 refugees were conducted, increasing understanding of the quantitative results. Results indicated that (1) the average refugee suffered 4-5 war traumas, (2) 80% showed clinical depression, (3) religion was of high importance (M = 5.8 on 7-point scale), reflecting strong religiousness in an officially Muslim culture, (4) positive religious coping was negatively associated with well-being (W-B), a relationship opposite to that found in studies of religious coping and W-B in safer (classroom) situations, raising a distinction between religiousness in high-stress vs. commonplace contexts, (5) 85% hoped to acculturate to Turkey by integrating its culture with their original culture, only 5% wished to assimilate, 7% wished to separate, keeping their original culture only, very few people marginalized to reject both their old and new culture, (6) assimilated refugees were more inclined to forgive the perpetrators, thus foster greater peace in the near term, (7) integrated refugees accepted two cultures, thereby showing capability to live with differences among people along with peaceful social justice in a multicultural world in the long run.

It is not too early to begin thinking about applying for the 2019 Travel Stipend and submitting a proposal or a poster for the APA Convention in Chicago. More information to come.

Say What? What Linguistic Analysis of Trauma Narratives Can Contribute to the Assessment and Prediction of Trauma Symptoms

Kaisa Marshall, Stephanie Gusler, and Lee R. Eshelman

Despite decades of research, there remains no gold standard of measurement and assessment of trauma experiences and related symptomatology. The lack of standardization in measurement comes, in part, from no clear definition of what constitutes traumatic stress (Kira et al., 2008). Additionally, there is little consensus as to which contextual factors are most important to examine, and there is great variability in the range of symptomatology that may come from the experience of trauma (Kira et al., 2008). An additional challenge in assessing trauma includes the heterogeneity of experiences. For example, two individuals who have exposure to the same type of trauma, such as physical abuse, may have very different experiences of the event and display different symptoms (Grant, Compas, Thurm, McMahon, & Gipson, 2004; Hoffman et al., 2014). Further, it is rare for individuals exposed to trauma to only experience a single traumatic event; it is far more likely for individuals exposed to trauma to have experienced multiple types of trauma, also known as cumulative trauma (Kira et al., 2008). Therefore, it becomes challenging to assess for all possible traumas and other individual factors that may influence symptoms. Linguistic Inquiry and Word Count (LIWC; Pennebaker, Booth, & Francis, 2007) is a novel approach to assessing trauma that may help to capture individual differences in experiences and address limitations of more commonly used assessment techniques.

Kaisa Marshall

Stephanie Gusler

Current popular methods of assessing trauma include checklists and structured and semi-structured interview methods (Grant et al., 2004). Checklists are efficient methods for quickly measuring the number and types of traumatic events experienced by individuals. Despite checklists' ease of use, this approach is limited in that it does not capture the heterogeneity of experiences and often assumes that one experience is objectively similar across individuals. Furthermore, checklists often lack a comprehensive list of all potential traumas and may miss events that are important for individuals (Grant et al., 2004). They also do not assess contextual information such as severity or duration of the event. A lack of contextual information surrounding traumatic events is a significant limitation, as factors such as duration of trauma, greater number of traumatic events, and an individual's gender may influence the perceived threat of an event and symptomatology (Frissa et al., 2016).

The use of interview techniques, such as the Traumatic Events Screening Inventory (TESI; Ford et al., 1996) or Clinical Administered PTSD Scale for DSM-5 (CAPS-5; Weathers et al., 2013), addresses many of the limitations of checklist measures by allowing interviewers to gain contextual information of experiences and assess a broad range of traumas and related symptoms (Grant et al., 2004). Interviews may be done in research contexts as well as in clinical practice. In clinical practice, these interviews may be less structured than in research and take the form of trauma narratives (i.e., victims' account of their experiences and their thoughts and feelings of the experiences) in Cognitive Behavioral Therapy (CBT; Westerman, Cobham, & McDermott, 2017). However, interviews in clinical or research settings are time-intensive to conduct, making them often infeasible in research settings where investigators are attempting to recruit large sample sizes or in clinical settings where time is limited for assessment of experiences and symptoms (Grant et al., 2004). Finding a balance in amount of information gained and time needed to obtain necessary information is critical. LIWC may be one approach to aide in finding this balance

Linguistic Inquiry and Word Count (LIWC)

Recently, LIWC has been used to evaluate symptomology and cognitive processing by analyzing victim's language when discussing traumatic experiences (Gray & Lombardo, 2001; Ng, Ahishakiye, Miller, & Meyerowitz, 2015; Marshall, Henderson, Barker, Sharp, Venta, 2017). LIWC is a computer program that analyzes language by searching for and counting psychologically-relevant words across multiple text files (Tausczik & Pennebaker, 2010). LIWC analyzes every word in a narrative and then places the word into a category. For instance, the word "the" is determined to be in the dictionary, and is then categorized as an article, whereas the word "hurt" would be put in the category emotionality and then specified as a negative emotion word. LIWC is also able to produce objective characteristics of the narrative, such as word count, narrative length, and use of speech fillers (Jaeger, Lindblom, Parker-Guilbert, & Zoellner, 2014).

Lee R. Eshelman

Overall, the goal of LIWC is to use objective linguistic data to glean information about an individual's cognitive processing, including attentional focus, emotionality, and thinking styles. Thus, LIWC evaluates language beyond the surface level content an individual is expressing and may provide more in-depth contextual data on trauma symptoms and processing. Recent research supports the use of LIWC's ability to tap into individual's well-being beyond their subjective report. Indeed, a recent study found that language use is able to predict the genetic expressions that are indicative of well-being better than individuals' reported affective experience, such as anxiety and stress (Mehl, Raison, Pace, Arevalo, & Cole, 2017). In other words, analyzing language use provides greater insight into individuals' mental health and overall well-being than their subjective report of health and affective experience.

Although it is beyond the scope of this article to fully review the literature, it is important to note that accumulating research suggests certain linguistic markers are particularly relevant in trauma narratives. Existing literature has found that emotion words, pronoun use, and cognitive process words to be the strongest predictors, as compared to other linguistic markers, of posttraumatic stress disorder (PTSD) symptoms. Additionally, increased word count and increased use of somatosensory detail (i.e., words that describe body states and perceptual experiences) have been shown to predict PTSD symptoms (Alvarez-Conrad, Zoellner, & Foa, 2001; Gray & Lombardo, 2001; Papini, Yoon, Rubin, Lopez-Castro, & Hien, 2015; Crespo & Fernández-Lansac, 2016). Although literature is primarily based on adult populations, findings have recently been replicated in adolescents as well (Marshall et al., 2017). More importantly though, there is evidence to suggest that analyzing an individual's language use can aid in the prediction of symptom change over time. To date, two studies have found that particular linguistic markers within trauma narratives—use of cognitive process words and somatosensory detail—predict trauma symptom change over time, in both adult and adolescent populations (D'Andrea et.al., 2012; Marshall et al., 2017). For instance, in trauma narratives following the September 11th terrorist attack, research found that greater use of cognitive process words predicted a longer duration of PTSD symptoms at a six-month follow-up. This finding was replicated in an adolescent inpatient sample, specifically in trauma accounts of sexual abuse, greater use of cognitive process words and fewer somatosensory details at intake predicted significant decreases in self-reported trauma symptoms at discharge. Such findings have important implications for the use of linguistic analysis in future research and clinical work.

Implications

LIWC is a useful tool for analyzing structural and content-related features of trauma narratives, a frequently used component of trauma-focused research and clinical work. Analyzing trauma narratives allows researchers to better understand contextual information specific to each participant, beyond the information gleaned from standardized assessments. However, designing, administering, and analyzing a comprehensive trauma-focused clinical interview takes hours of preparation and training. This immense task is often an inefficient use of researcher's time, particularly when more efficient methods exist. Researchers can use LIWC software to quickly and reliably analyze the structural and content-related features of trauma narratives. Importantly, LIWC can be administered by research assistants with relatively little training (Marshall et al., 2017), bypassing a time-intensive requirement for training trauma-informed clinicians and researchers in collecting and analyzing these narratives.

LIWC can also be used as a novel approach to analyze electronic data gathered from a broader sample of trauma survivors who may be unable or unwilling to attend an in-person research study session. Researchers have used LIWC software to analyze web-based writing about traumatic and/or stressful life events on blogs (Hoyt & Pasupathi, 2008), Twitter (Coppersmith, Harman, & Dredze, 2014), and Amazon Mechanical

Turk (Grysman, 2015), a website where individuals can complete studies for monetary compensation. These methods allow researchers to move beyond the reliance on convenience college samples, which increases generalizability of findings.

LIWC can also be used in clinical work to assess overall trauma symptomology in conjunction with self-report measures and identify markers of recovery. Trauma narratives are a key feature of many evidence-based trauma interventions including the verbal trauma account portion of imaginal exposure in Prolonged Exposure Therapy (Foa, Hembree & Rothbaum, 2007), the impact statement about the personal meaning of the traumatic event used in Cognitive Processing Therapy (CPT), and the written trauma account in CPT + Account (Resick, Monson & Chard, 2016). While components of trauma narratives have been found to reflect overall trauma symptomology (Jaeger et al., 2014), LIWC can also parse out detailed linguistic markers indicative of specific features of PTSD. Crespo and Fernández-Lansac (2016) reviewed 22 studies that used linguistic procedures to evaluate trauma narratives and connected specific linguistic features to PTSD symptomology. Narrative disorganization and fragmentation (e.g., repetitions, unfinished utterances, and speech fillers), emotional and sensory/perceptual aspects, and references to self were all related to overall PTSD symptomology across studies (Crespo & Fernandez-Lansac, 2016).

Clinicians can use LIWC to analyze trauma accounts to better tailor interventions to the patient's specific needs. For example, trauma accounts with increased references to self, particularly related to actions or inactions during the traumatic event, may be indicative of distorted self-blame which can be targeted during treatment. Furthermore, patients often complete trauma narratives at multiple timepoints during treatment, often highlighting pre/post markers of recovery. LIWC can be used to track linguistic markers in the trauma narratives associated with trauma symptom improvements (D'Andrea et.al., 2012; Marshall et al., 2017).

LIWC is not without some limitations however, as the software has difficulty accurately categorizing more complex components of writing including sarcasm, metaphors, and idioms (Iliev, Dehgani, & Sagi, 2014). The use of a computerized system also creates opportunities to mischaracterize writing that would be caught by human eyes. Back, Kufner, and Egloff (2010) analyzed text messages sent in the aftermath of September 11, 2001 and found that anger-related words were widespread and increasing for more than 12 hours after the attack. However, a reanalysis of the data (Pury, 2011) found that messages automatically generated by cell companies (e.g., 'critical' server problems) were coded as anger-related emotional content, thus overinflating the findings. Additional work is clearly needed to improve text analysis software to reach accuracy levels of human coders, the "gold standard" in analyzing complex language (Iliev et al., 2014). Researchers and clinicians must carefully consider how to balance the ease and efficiency of automated text analysis software with the precise accuracy of a hands-on approach.

In sum, LIWC aims use objective linguistic data to evaluate language in a trauma narrative beyond the surface level content an individual is expressing in an attempt to provide more in-depth data on trauma symptoms and processing. Existing literature has found specific linguistic markers which are associated with trauma symptomology, and although limited, recent research has suggested promising results of the ability of linguistic markers to predict trauma symptom change over time. Thus, although LIWC is not a trauma specific measure it can contribute meaningful, objective data that can be integrated with other trauma symptom assessments (e.g., CAPS-5) to provide a more comprehensive picture of an individual's trauma symptoms. As the field as a whole strives to improve the accuracy of assessing trauma symptoms and effectively treat symptoms, LIWC is one source that can provide additional information.

References

Alvarez-Conrad, J., Zoellner, L. A., & Foa, E. B. (2001). Linguistic predictors of trauma pathology and physical health. *Applied Cognitive Psychology*, *15*(7), S159–S170. doi:10.1002/acp.839

Back, M. D., Küfner, A. C., & Egloff, B. (2010). The emotional timeline of September 11, 2001. *Psychological Science*, *21*(10), 1417-1419.

Coppersmith, G., Dredze, M., & Harman, C. (2014). Quantifying mental health signals in Twitter. In Proceedings of the Workshop on Computational Linguistics and Clinical Psychology: From Linguistic Signal to Clinical Reality (pp. 51-60).

Crespo, M., & Fernández-Lansac, V. (2016). Memory and narrative of traumatic events: A literature review. *Psychological Trauma: Theory, Research, Practice, and Policy*, *8*(2), 149–156. doi:10.1037/tra0000041

D'Andrea, W., Chiu, P. H., Casas, B. R., & Deldin, P. (2012). Linguistic predictors of post□traumatic stress disorder symptoms following 11 September 2001. *Applied Cognitive Psychology*, *26*(2), 316–323. doi:10.1002/acp.1830

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). Prolonged exposure therapy for PTSD. New York: Oxford University.

Frissa, S., Hatch, S. L., Fear, N. T., Dorrington, S., Goodwin, L., & Hotopf, M. (2016). Challenges in the retrospective assessment of trauma: Comparing a checklist approach to a single item trauma experience screening question. *BMC Psychiatry, 16*, 9. doi:10.1186/s12888-016-0720-1

Grant, K. E., Compas, B. E., Thurm, A. E., McMahon, S. D., & Gipson, P. Y. (2004). Stressors and child and adolescent psychopathology: Measurement issues and prospective effects. *Journal of Clinical Child and Adolescent Psychology, 33*(2), 412-425. doi:10.1207/s15374424jccp3302_23

Gray, M. J., & Lombardo, T. W. (2001). Complexity of trauma narratives as an index of fragmented memory in PTSD: A critical analysis. *Applied Cognitive Psychology*, *15*(7), S171–S186. doi:10.1002/acp.840

Grysman, A. (2015). Collecting narrative data on Amazon's Mechanical Turk. *Applied Cognitive Psychology*, 29(4), 573-583.

Hoffman, K., Cole, E., Playford, E. D., Grill, E., Soberg, H. L., & Brohi, K. (2014). Health outcome after major trauma: What are we measuring? *PLoS ONE, 9*(7), 11. doi: 10.1037/t07023-000

Hoyt, T., & Pasupathi, M. (2008). Blogging about trauma: Linguistic

markers of apparent recovery. *E-Journal of Applied Psychology*, *4*(2), 56-62.
Iliev, R., Dehghani, M., & Sagi, E. (2015). Automated text analysis in psychology: Methods, applications, and future developments. *Language and Cognition*, *7*(2), 265-290.
Jaeger, J., Lindblom, K. M., Parker-Guilbert, K., & Zoellner, L. A. (2014). Trauma narratives: It's what you say, not how you say it. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(5), 473–481. doi:10.1037/a0035239
Kira, I. A., Lewandowski, L., Templin, T., Ramaswamy, V., Ozkan, B., & Mohanesh, J. (2008). Measuring cumulative trauma dose, types, and profiles using a development-based taxonomy of traumas. *Traumatology, 14*(2), 62-87. doi:10.1177/1534765608319324
Marshall, K., Venta, A., Henderson, C., Barker, M., & Sharp, C. (2017). Linguistic analysis as a method for assessing symptoms after sexual trauma among female adolescent psychiatric inpatients. *Journal of Child Sexual Abuse*, *26*(8), 910-926.
Mehl, M. R., Raison, C. L., Pace, T. W. W., Arevalo, J. M. G., & Cole, S. W. (2017). Natural language indicators of differential gene regulation in the human immune system. *Proceedings of the National Academy of Sciences*, *114*(47), 12554–12559. https://doi.org/10.1073/pnas.1707373114
Ng, L. C., Ahishakiye, N., Miller, D. E., & Meyerowitz, B. E. (2015). Narrative characteristics of genocide testimonies predict posttraumatic stress disorder symptoms years later. *Psychological Trauma: Theory, Research, Practice, and Policy*, *7*(3), 303–311. doi:10.1037/tra0000024
Papini, S., Yoon, P., Rubin, M., Lopez-Castro, T., & Hien, D. A. (2015). Linguistic characteristics in a non-trauma-related narrative task are associated with PTSD diagnosis and symptom severity. *Psychological Trauma: Theory, Research, Practice, and Policy*, *7*(3), 295–302. doi:10.1037/tra0000019
Pennebaker, J. W., Booth, R. J., & Francis, M. E. (2007). Linguistic Inquiry and Word Count: LIWC [Computer software]. Austin, TX: LIWC.net
Pury, C. L. (2011). Automation can lead to confounds in text analysis: Back, Küfner, and Egloff (2010) and the not-so-angry Americans. *Psychological Science*, *22*(6), 835.
Resick, P. A., Monson, C. M., & Chard, K. M. (2016). Cognitive processing therapy for PTSD: A comprehensive manual. Guilford Publications.
Tausczik, Y. R., & Pennebaker, J. W. (2010). The psychological meaning of words: LIWC and computerized text analysis methods. *Journal of Language and Social Psychology*, *29*(1), 24–54. doi:10.1177/0261927X09351676
Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The PTSD Checklist for DSM–5 (PCL-5). Retrieved from www.ptsd.va.gov
Westerman, N. K., Cobham, V. E., & McDermott, B. (2017). Trauma-focused cognitive behavior therapy: Narratives of children and adolescents. *Qualitative Health Research, 27*(2), 226-235. doi:10.1177/1049732315627795

Kaisa Marshall *is a fourth-year doctoral student in the clinical psychology program at Sam Houston State University. Broadly, her research focuses on the assessment and prediction of trauma symptoms, and more specifically, how the language individuals use to discuss their trauma relates to their symptomology. She is also interested in how early traumatic experiences influence a youth's developmental functioning and later interactions with the justice system and treatment response. In the future, Kaisa plans to continue her research and clinical work with clients experiencing trauma symptoms, particularly justice-involved youth.*

Stephanie Gusler *received her M.A. in Psychology from Wake Forest University. She is currently a doctoral student in Clinical Child Psychology at the University of Kansas. Her primary research focus is on mechanisms, such as appraisals of trauma and emotion regulation, that may help explain the intergenerational continuity of trauma from parent to child. Stephanie hopes to implement research that can be used to inform interventions for parents who experienced childhood maltreatment, to help prevent the continuation of trauma for their children.*

Lee R. Eshelman, PhD *recently graduated from the clinical psychology program at Miami University and completed her internship at the University of Wisconsin Department of Psychiatry. She is currently the Women's Health postdoctoral fellow with the University of Michigan/Ann Arbor VAMC Consortium.*

Social Media News

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

Military PTSD and Post-service Violence: A Review of the Evidence

Joshua Camins, M.A.
Sam Houston State University

One of the most commonly discussed sequalae of stressful deployment experiences is posttraumatic stress disorder (PTSD). Estimates of military service-connected PTSD range from 8.1% to 23% with the rates varying by conflict at time of service (Fulton et al., 2015; Gradus, 2017). Over the last two decades, there have been many instances in which post-deployment veterans have demonstrated violence. Although not all of these individuals have a diagnosis of PTSD, these instances often evoke sensationalized connections between PTSD and violence (e.g., Lamothe, 2015). Given the number of veterans impacted by PTSD, the relationship between military PTSD and violence warrants exploration. This article reviews the relationships between PTSD and criminal offending, a PTSD diagnosis and violence/aggression, and PTSD symptom clusters and violence/aggression. This information is particularly relevant in the context of understanding best practices for violence risk assessment with veterans.

Joshua Camins

PTSD and Criminal Offending

Data from the Bureau of Justice Statistics indicates that 1 in 35 adults in the U.S., approximately 2.8% of the population, are involved with the legal system (Kaeble & Glaze, 2014). Current estimates suggest approximately 8% of all inmates in U.S. jails and prisons are military veterans (Bronson, Carson, Noonan, & Berzofsky, 2015). Although rates of veteran incarceration are proportionally lower than civilian counterparts (May, Stives, Wells, & Wood, 2016), understanding what influences veteran offending is crucial for detection and prevention. The rates and type of offending in veterans varies based on era of service. For example, relative to veterans from other eras, Operation Enduring Freedom (OEF)/Operation Iraq Freedom (OIF)/Operation New Dawn (OND) veterans appear to be incarcerated at a lower rate (Tsai, Rosenheck, Kasprow, & McGuire, 2013). A plethora of research has explored predictors of criminal justice involvement in civilians, including the utility of PTSD and other mental health related issues. One study found a PTSD diagnosis was associated with 1.4 times higher odds of criminal recidivism in civilians (Sadeh & McNiel, 2015). Data suggests veteran offenders from the most recent conflict eras (i.e., OEF/OIF/OND) are three times more likely to have a combat-related diagnosis of PTSD (Tsai, Rosenheck, Kasprow, & McGuire, 2013).

Findings from Elbogen and colleagues' (2012a) study suggest 9% of recent conflict veterans had been arrested since returning from deployment. PTSD in combination with high irritability was predictive of post-deployment arrest (Elbogen et al., 2012a). Despite consistent findings in veterans, research with active duty servicemembers is mixed. Findings from a large-scale study on predictors of minor violent crime perpetration in military servicemembers suggest that although outpatient use of services for mental health, martial, or stressor-related problems predict contact, specific diagnoses (i.e., PTSD) were not in the final model (Rosellini et al., 2017). In contrast, a stress-related disorder was predictive of major violence in male servicemembers only (Rosellini et al., 2016). Although inconsistent with veteran samples, these findings suggest problematic symptoms may not emerge until later. Thus, although PTSD may be relevant, individuals with clinically significant PTSD may either be medically discharged, or not experience distress until after service.

PTSD and Aggression

There is consistent evidence that PTSD symptoms are associated with increased expressions of anger and aggressive behavior in veterans (Elbogen, Johnson, & Beckham, 2011; Blongien et al., 2016). The relationship between PTSD and intimate partner violence is also well established in the literature (Elbogen et al., 2010). In a study by Elbogen and colleagues (2012b), 33% of the veteran sample reported at least one act of violence or aggression in the community as measured by endorsement of specific items on the Conflict Tactics Scale (e.g., "beat up another other person") or MacArthur Community Violence Scale (e.g., "threaten anyone with a gun or knife"). The authors determined that a probable diagnosis of PTSD yielded higher odds of severe violence or physical aggression (Elbogen et al., 2012b). However, multiple studies have suggested intermediate factors may account for the relationship. In one study,

after controlling for the co-occurrence of alcohol use or anger, the impact of a PTSD diagnosis on the prediction of violent behavior was non-significant (Blakey, Love, Linquist, Beckham, & Elbogen, 2017).

The interaction between substance use and PTSD is consistent across the studies reviewed (e.g., Blonigen et al., 2016). Data collected from a multi-wave study indicate there was no significant difference in *serious* violence perpetration between veterans diagnosed with PTSD without co-occurring alcohol use problems and veterans without a PTSD diagnosis or problematic alcohol use; however, there perpetration of less severe aggression was more common in veterans with PTSD (Elbogen et al., 2014). Other factors that have been identified as possibly playing an intermediate role include hostility (Sippel et al., 2016), impulsivity (Heinz et al., 2015), and anger (Novaco & Chemtob, 2015). For example, Wilk and Colleagues (2015) found a connection between PTSD and aggression at high levels of trait anger but not at low levels of trait anger (Wilk et al., 2015).

PTSD Symptoms and Aggression

To better understand PTSD and aggression, researchers have explored the relationship between PSTD symptom clusters and aggression. Van Voorhees and colleagues (2016) observed that all three DSM-IV-TR PTSD symptom clusters were equally predictive of aggression in a longitudinal sample. However, cross-sectional analysis identified the hyperarousal cluster as increasing odds of aggression. The authors also identified hostility as a mechanism impacting the relationship between PTSD status and physical aggression. Specifically, hostility increased risk of aggression.

The hyperarousal cluster is consistently associated with increased trait anger, aggression, and violence (Elbogen et al., 2010; Elbogen et al., 2011). Although the association may be exacerbated by veteran substance use (Elbogen et al., 2010), there is ample evidence to support this assertion (e.g., Donley et al., 2012; Makin-Byrd et al., 2012; Van Voorhees et al., 2016). In contrast, elevations in the avoidance/numbing cluster appear to be predictive of violence in some, but not all samples (Elbogen et al., 2010). In a different study examining specific PTSD symptoms, although anger symptoms predicted family violence, symptoms associated with flashbacks, being on guard, numb, or physically upset were not predictive (Sullivan & Elbogen, 2014). Within the same framework, the authors observed violence towards strangers was predicted by flashbacks but not anger symptoms, being on guard, numb, or physically upset (Sullivan & Elbogen, 2014).

Conclusions

Although PTSD represents one risk factor that is correlated with criminal behaviors, aggression, and violence, the literature does not elucidate a causal relationship. Rather, the available data suggest other factors (e.g., substance use or trait anger) may strengthen or weaken the relationship between PTSD and criminal offending, aggression, and violence. Regardless, the potential impact of PTSD on the lives of servicemembers is substantial. In making decisions about PTSD and potential dangerousness, it is imperative that careful assessment be conducted (Elbogen et al., 2010). Although a diagnosis of PTSD or PTSD symptoms may increase the likelihood of violence, factors such as substance use and trait anger also impact potential dangerousness and should be considered in evaluating risk (Elbogen et al., 2010). The use of violence risk instruments and an in-depth clinical interview will help elucidate patient-specific risk factors (Elbogen et al., 2010; Elbogen et al., 2014). Ultimately, psychological and, if necessary, crime-reducing t treatments (e.g., Moral Reconation Therapy) should be administered only after considering all potential risk factors for criminal offending and violence, not just the presence or absence of PTSD (Timko et al., 2014).

References

Blakey, S. M., Love, H., Lindquist, L., Beckham, J. C., & Elbogen, E. B. (2018). Disentangling the link between posttraumatic stress disorder and violent behavior: Findings from a nationally representative sample. *Journal of Consulting And Clinical Psychology, 86(2), 169-178. doi:10.1037/ccp0000253*

Blonigen, D. M., Bui, L., Elbogen, E. B., Blodgett, J. C., Maisel, N. C., Midboe, A. M., & ... Timko, C. (2016). Risk of Recidivism Among Justice-Involved Veterans. *Criminal Justice Policy Review*, *27*(8), 812-837. doi:10.1177/0887403414562602

Bronson, J., Carson, E.A., Noonan, M., & Berzofsky, M. (2015). *Veterans in prison and jail* (NCJ 249144). Retrieved from http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5479

Donley, S., Habib, L., Jovanovic, T., Kamkwalala, A., Evces, M., Egan, G., & ... Ressler, K. J. (2012). Civilian PTSD symptoms and risk for involvement in the criminal justice system. *Journal Of The American Academy Of Psychiatry And The Law*, *40*(4), 522-529.

Elbogen, E. B., Cueva, M., Wagner, H. R., Sreenivasan, S., Brancu, M., Beckham, J. C., & Van Male, L. (2014). Screening for violence risk in military veterans: predictive validity of a brief clinical tool. *The American Journal Of Psychiatry*, *171*(7), 749-757. doi:10.1176/appi.ajp.2014.13101316

Elbogen, E. B., Fuller, S., Johnson, S. C., Brooks, S., Kinneer, P., Calhoun, P. S., & Beckham, J. C. (2010). Improving risk assessment of violence among military veterans: an evidence-based approach for clinical decision-making. *Clinical Psychology Review*, *30*(6), 595-607. doi:10.1016/j.cpr.2010.03.009

Elbogen, E. B., Johnson, S. C., & Beckham, J. C. (2011). Anger, aggression, and violence. In B. A. Moore, W. E. Penk, B. A. Moore, W. E. Penk (Eds.) , *Treating PTSD in military personnel: A clinical handbook* (pp. 305-324). New York, NY, US: Guilford Press.

Elbogen, E. B., Johnson, S. C., Newton, V. M., Straits-Troster, K., Vasterling, J. J., Wagner, H. R., & Beckham, J. C. (2012). Criminal justice involvement, trauma, and negative affect in Iraq and Afghanistan war era veterans. *Journal of Consulting And Clinical Psychology*, *80*(6), 1097-1102. doi:10.1037/a0029967

Elbogen, E. B., Johnson, S. C., Wagner, R., Newton, V. M., Timko, C., Vasterling, J. J., & Beckham, J. C. (2012). Protective factors and risk modification of violence in Iraq and Afghanistan war veterans. *The Journal of Clinical Psychiatry*, *73*(6), e767-e773. doi:10.4088/JCP.11m07593

Elbogen, E. B., Johnson, S. C., Newton, V. M., Timko, C., Vasterling, J. J., Van Male, L. M., & ... Beckham, J. C. (2014). Protective mechanisms and prevention of violence and aggression in veterans. *Psychological Services*, *11*(2), 220-228. doi:10.1037/

a0035088
Elbogen, E. B., Johnson, S. C., Wagner, H. R., Sullivan, C., Taft, C. T., & Beckham, J. C. (2014). Violent behaviour and post-traumatic stress disorder in US Iraq and Afghanistan veterans. *The British Journal of Psychiatry*, *204*(5), 368-375. doi:10.1192/bjp.bp.113.134627
Fulton, J. J., Calhoun, P. S., Wagner, H. R., Schry, A. R., Hair, L. P., Feeling, N., & ... Beckham, J. C. (2015). The prevalence of posttraumatic stress disorder in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans: A meta-analysis. *Journal of Anxiety Disorders*, *31,* 98-107. doi:10.1016/j.janxdis.2015.02.003
Gradus, J. (2017). Epidemiology of PTSD. *PTSD: National Center for PTSD.* Retrieved from http://www.ptsd.va.gov/professional/PTSD-overview/epidemiological-facts-ptsd.asp
Kaeble, D., & Glaze, L., (2016). *Correctional Populations in the United States, 2015* (NCJ 250374). Retrieved from http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5870
Lamothe, D. (2015, February 10). 'American Sniper' trial: Dissecting the PTSD claim of Eddie Ray Routh. *The Washington Post*. Retrieved from www.washingtonpost.com
May, D. C., Stives, K. L., Wells, M. J., & Wood, P. B. (2017). Does Military Service Make the Experience of Prison Less Painful? Voices From Incarcerated Veterans. *Criminal Justice Policy Review, 28(8), 770-789. doi:10.1177/0887403416628600*
Novaco, R. W., & Chemtob, C. M. (2015). Violence associated with combat-related posttraumatic stress disorder: The importance of anger. *Psychological Trauma: Theory, Research, Practice, and Policy*, *7*(5), 485-492. doi:10.1037/tra0000067
Rosellini, A. J., Monahan, J., Street, A. E., Hill, E. D., Petukhova, M., Reis, B. Y., & ... Kessler, R. C. (2017). Using administrative data to identify U.S. Army soldiers at high-risk of perpetrating minor violent crimes. *Journal of Psychiatric Research*, *84,* 128-136. doi:10.1016/j.jpsychires.2016.09.028
Rosellini, A. J., Monahan, J., Street, A. E., Heeringa, S. G., Hill, E. D., Petukhova, M., & ... Kessler, R. C. (2016). Predicting non-familial major physical violent crime perpetration in the US Army from administrative data. *Psychological Medicine*, *46*(2), 303-316. doi:10.1017/S0033291715001774
Sadeh, N., & McNiel, D. E. (2015). Posttraumatic stress disorder increases risk of criminal recidivism among justice-involved persons with mental disorders. *Criminal Justice and Behavior*, *42*(6), 573-586. doi:10.1177/0093854814556880
Sippel, L. M., Mota, N. P., Kachadourian, L. K., Krystal, J. H., Southwick, S. M., Harpaz-Rotem, I., & Pietrzak, R. H. (2016). The burden of hostility in U.S. Veterans: Results from the National Health and Resilience in Veterans Study. *Psychiatry Research, 243, 421-430. doi:10.1016/j.psychres.2016.06.040*
Sullivan, C. P., & Elbogen, E. B. (2014). PTSD symptoms and family versus stranger violence in Iraq and Afghanistan veterans. *Law and Human Behavior*, *38*(1), 1-9. doi:10.1037/lhb0000035
Timko, C., Midboe, A. M., Maisel, N. C., Blodgett, J. C., Asch, S. M., Rosenthal, J., & Blonigen, D. M. (2014). Treatments for recidivism risk among justice-involved veterans. *Journal of Offender Rehabilitation*, *53*(8), 620-640. doi:10.1080/10509674.2014.956964
Tsai, J., Rosenheck, R. A., J Kasprow, W., & McGuire, J. F. (2013). Risk of incarceration and other characteristics of Iraq and Afghanistan era veterans in state and federal prisons. *Psychiatric Services (Washington, D.C.), 64(1), 36-43. doi:10.1176/appi.ps.201200188*
Van Voorhees, E. E., Dennis, P. A., Neal, L. C., Hicks, T. A., Calhoun, P. S., Beckham, J. C., & Elbogen, E. B. (2016). Posttraumatic stress disorder, hostile cognitions, and aggression in Iraq/Afghanistan era veterans. Psychiatry: Interpersonal and Biological Processes, 79(1), 70-84. doi:10.1080/00332747.2015.1123593
Wilk, J. E., Quartana, P. J., Clarke□Walper, K., Kok, B. C., & Riviere, L. A. (2015). Aggression in US soldiers post-deployment: Associations with combat exposure and PTSD and the moderating role of trait anger. *Aggressive Behavior*, *41*(6), 556-565. doi:10.1002/ab.21595

Joshua Camins *is a fifth-year doctoral student at Sam Houston State University in Huntsville, Texas. He conducts research at the intersection of forensic and military psychology. In addition to research, he is involved in a variety of clinical activities including trauma treatment with veterans, forensic evaluations in a state hospital, and psychotherapy with psychiatric patients.*

All correspondence should be addressed to Joshua Camins, M.A., Sam Houston State University, 1526 Avenue J, Huntsville, TX 77379. Phone (609) 731-3945. E-mail: JCamins@shsu.edu

NEW FELLOW

New Fellow: Eileen Zurbriggen

I am a feminist social psychologist and have been a professor at the University of California, Santa Cruz for 18 years. My research focuses on the causes and consequences of behaviors that connect power and sexuality, from the most traumatic (e.g., sexualized torture, rape, childhood sexual abuse) to those with less obvious traumatic impact (e.g., the objectification of women and girls, the use of children as nude models in art photography). I aim to theorize how different kinds of traumas at different levels are related to each other. For example, in my article theorizing links between rape and war (Zurbriggen, 2010; *Psychology of Women Quarterly*), I argued that rape in all settings (not just wartime rape) is intimately linked with war-making because the same type of aggression-focused masculine socialization underlies both phenomena. In some ways this is a discouraging insight (because it makes the problem of eliminating rape seem all the more intractable) but in other ways it is hopeful (because every action that works against rape also works against war and vice versa). I developed two undergraduate courses on trauma (*Psychology of Trauma* and *Psychology of Sexual Aggression)* which have been taken by over 1000 students and I published an article describing practices that can help minimize the chances of secondary trauma in the undergraduate classroom (Zurbriggen, 2011, *Psychological Trauma: Theory, Research, Practice, and Policy).* I'm on the editorial board of the *Journal of Trauma and Dissociation,* am a charter member of Division 56 and am deeply honored to be selected as a fellow. My advice to new trauma psychologists is "Don't go it alone." We all need support to do the difficult but important work we have chosen. Working together, we can do much more to heal the world from violence and trauma than we can on our own.

Who's Who: Wyatt Evans, PhD

1) What is your current occupation?

I am a postdoctoral fellow with the University of Texas Health Science Center at San Antonio. Currently, I'm serving as a research therapist for STRONG STAR and the Consortium to Alleviate PTSD (CAP) at Fort Hood. I support two clinical trials of Prolonged Exposure delivered in massed and online formats to active duty service members and veterans. I am also involved in research through the VA and at the National Center for PTSD (NC-PTSD).

Wyatt Evans

2) Where were you educated?

I completed my undergraduate training at the University of Texas at Dallas and my graduate training at Palo Alto University under the mentorship of Dr. Kimberly Balsam. While in graduate school, I completed additional research and clinical training at the NC-PTSD with Drs. Shannon Wiltsey-Stirman and Robyn Walser. I completed my pre-doctoral internship at the Michael E. DeBakey VA Medical Center in Houston, TX. In my fellowship at UT Health San Antonio, I am honored to work with and receive mentorship from a number of leading trauma researchers and clinicians including Drs. Alan Peterson and Edna Foa.

3) Why did you choose this field?

I started school as a music major, so it only makes sense that I'd become a trauma psychologist, right? Maybe not, but once I made the switch to psychology, I quickly felt most compelled to study the effects of trauma and how to best facilitate healing when trauma led to enduring wounds. I first studied minority stress and interpersonal trauma among minority populations. In graduate school, I then had the opportunity to do research and clinical work at the Palo Alto VA and at the NC-PTSD. This facilitated some shift in my focus to trauma and PTSD among military populations, which allowed me to connect some of my professional and personal values. The most recent shift was from VA service to primarily serving active duty service members. I feel especially rewarded working with active duty service members, as it enables me to potentially intervene most proximally to the stressors.

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

I feel very lucky to have found that elusive "balance" between direct clinical care and research. I was always told finding that 50/50 split was impossible and, while it may not be an even split every day, I get to do all I want of both. There is so much going on at STRONG STAR-CAP that's making a difference in the lives of service members and veterans – by developing and improving treatments available to them and by disseminating these interventions to providers who serve them. I am so pleased to be a part of each of these efforts!

5) What is most frustrating about your work?

I guess the answer to this is the inverse of everything I said in response the last question. There are so many opportunities and so much I want to do but not enough hours in the day (or coffee) to make everything happen right away.

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

I *try* to balance the hours spent in the office with time outdoors. Now that I'm back home in Texas, I visit family as often as I can. The best visits home also include some fishing. I also try to have at least a short trip to visit grad school friends somewhere on the calendar at all times.

7) What are your future plans?

That's a good question! I'm in the second year of my fellowship now and so am putting an increasing amount of energy into figuring out what comes next. I know that, whatever I do, I will continue to support and provide high quality care to military service members and/or veterans struggling in the aftermath of trauma.

Trauma Assessment Video Training with High-Risk Trauma Diverse Clients

Bryann B. DeBeer & Diane T. Castillo

Research has demonstrated that individuals who are female and/or from diverse backgrounds are subject to higher rates of Post-Traumatic Stress Disorder (PTSD) than their majority counterparts. The rates of PTSD in the general population are 8% for males and 20% for females (Kessler, 2000). Individuals with disabilities, particularly women, experience higher rates of trauma and PTSD (33.4%) compared to non-disabled individuals (18.4%; Powers, Curry, Oschwald, Maley, Saxton, & Eckels, 2002). The risk of developing PTSD in lesbian, gay, bisexual, transgender (LGBT) persons is higher (22.3%) than heterosexuals (12.5%; Roberts, Austin, Corliss, Vandermorris, Koenen, 2010). In Veterans, the prevalence of PTSD is 15% in males and 25% in females (Kessler, Chiu, Demler, & Walters, 2005), though males experience a higher number of traumatic events. Finally, the highest rates of PTSD in male Veterans are found in African Americans (20%) and Hispanics (29%), compared to 15% in general (Dohrenwend, Turner, Turse, Lewis-Fernandez, & Yager, 2008). These findings suggest minorities and women are particularly vulnerable to developing PTSD and, as such, need special attention in assessment and treatment.

Bryann B. DeBeer

Diane T. Castillo

The assessment and treatment of PTSD has received much attention since the identification of the disorder by the Diagnostic and Statistical Manual of Mental Disorders-III (American Psychiatric Association, 1980) and evidence-based guidelines have been developed for both. However, little focus has been on the assessment of trauma events, essential to the diagnosis of PTSD. Assessment of traumatic events has relied upon either self-report scales, such as the Life Events Checklist (LEC; Gray, Litz, Hsu, & Lombardo, 2004), or more commonly, open-ended, unstructured questions posed by the clinician. Neither of these methods provide guidance to the clinician in asking questions about trauma events in general, nor importantly to the unique trauma experiences of diverse populations and particularly highly vulnerable populations such as ethnic minorities, LGBT individuals, women, and disabled persons.

This project represents an attempt to address this gap in training of the non-trauma clinician and to create an educational tool for psychologist clinicians and other therapists to identify nuances specific to high-risk trauma clients (HRTC) in the assessment of trauma events in these individuals. Such guidance to the clinician is important for several reasons. First, avoidance is a key symptom of PTSD in individuals diagnosed with PTSD, which is displayed in guarding and withholding trauma information. Next, avoidance is compounded in HRTC population's mistrust toward clinicians representing the dominant culture and may withhold more information. Finally, trauma events may and often occur within the context of discrimination (e.g., interactions with the police) and are likely difficult for the client to discuss with a therapist of another race who does not face such discrimination. A clinician lacking direction could prevent the accurate assessment of traumatic events, leading to poorer PTSD diagnostic assessment and/or impeding progress in treatment. Non-trauma clinicians and early career therapists are at a disadvantage with little guidance. While experienced trauma clinicians may have developed the skills in eliciting trauma information, they too may benefit from an assessment video that provides direction with HRTC populations.

In order to address these issues, Division 56 President Dr. Diane Castillo, and Division 56 Social Media Chair, Dr. Bryann DeBeer, applied for a Council on Division/APA Relations grant to create innovative educational videos on how to assess trauma in HRTCs. These videos will be targeted towards psychology students, and early career psychologists to be used as a tool to further education regarding HRTCs. The goals of this CODAPAR grant are to:

1) increase the knowledge of general practice psychologists in the assessment of trauma in high-risk, trauma-vulnerable populations, specifically in women, LGBT persons, individuals with disabilities, and ethnically diverse Veterans in a culturally sensitive/responsive manner; 2) develop and create training videos of assessment interviews with above populations, identifying and noting pertinent details in each interview; 3) provide incentives to complete clinician training with free CEUs. We have partnered with several other APA Divisions: Division 17 – Counseling Psychology (Dr. Ruth Fassinger), Division 22 – Rehabilitation Psychology (Dr. Sarah-Rae Andreski, & Dr. Michelle Meade), Division 35 – Psychology of Women (Dr. Thema Bryant, & Dr. Khan Dinh), Division 44 – Society for the Psychology of Sexual Orientation and Gender Diversity (Dr. Gary Howell, Dr. David Pantalone, & Dr. Shay Caramiello). With Division 22, we are developing a video which focuses on a client with multiple sclerosis. In partnership with Division 35, we are developing a video which focuses on a black female who has experienced sexual assault. With Division 44, we are developing a video which focuses on a trans woman. Finally, the Division 56 video will focus on a male Hispanic combat veteran. The videos will be completed at the end of 2018, and will be disseminated through the Division 56 listserve and website, among other dissemination tools.

References

American Psychiatric Association (1980). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, DC: Author.

Dobie, D. J., Kivlahan, D. R., Maynard, C., Bush, K.R., Davis, T. M., & Bradley, K. A. (2004). PTSD in female veterans: association with self-reported health problems and functional impairment. *Archives of Internal Medicine, 164,* 394-400.

Dohrenwend, B. P., Turner, J. B., Turse, N. A., Lewis-Fernandez, R., & Yager, T. J. (2008). War-related posttraumatic stress disorder in Black, Hispanic, and majority White Vietnam veterans: The roles of exposure and vulnerability. *Journal of Traumatic Stress, 21,* 133–141.

Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric properties of the life events checklist. *Assessment, 11,* 330-341.

Kessler, R. C., (2000). Posttraumatic Stress Disorder: The Burden to the Individual and to Society. *Journal of Clinical Psychiatry, 61* (suppl 5), 4-12.

Kessler, R.C., Chiu, W.T, Demler, O., & Walters, E.E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62,* 617-627.

Powers, L. E., Curry, M. A., Oschwald, M., Maley, S., Saxton, M., & Eckels, K. (2002). Barriers and strategies in addressing abuse: A survey of disabled women's experiences. *Journal of Rehabilitation, 68,* 4–13.

Roberts, A. L., Austin, S. B., Corliss, H. L., Vandermorris, A. K., & Koenen, K. C. (2010). Pervasive trauma exposure among US sexual orientation minority adults and risk of posttraumatic stress disorder. *American Journal of Public Health, 100,* 2433- 2441.

***Bryann DeBeer, Ph.D.**, is the Director of the VA Patient Safety Center of Inquiry for Suicide Prevention and a Clinical Research Psychologist at the VISN 17 Center of Excellence for Research on Returning War Veterans within the U.S. Department of Veterans Affairs. Dr. DeBeer is also an Assistant Professor in the Department of Psychiatry & Behavioral Sciences at the Texas A&M College of Medicine, as well as the Program Chair and Social Media Committee Chair of Division 56 (Trauma) of the American Psychological Association. Dr. DeBeer's research interests include trauma exposure and suicide risk in Veteran populations.*

***Diane T. Castillo, Ph.D.** is the President of APA's Trauma Division (56) and is an Associate Editor for the APA journal Psychological Trauma. She is a trainer and consultant in Prolonged Exposure (PE) therapy and group treatments with evidence-based treatments for PTSD. She has worked in the field of PTSD for over 30 years as a clinician, researcher, educator, and administrator, primarily in the VA. She has developed evidence-based assessments and treatments for Veterans with PTSD. She has served on the Board of Directors for ISTSS. Dr. Castillo has served on faculty at Texas A&M University and the University of New Mexico. She has published in the areas of PTSD, Hispanic veterans, and ethics.*

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.

Be Part of the Conversation

Division 56 was founded to keep trauma and its effects at the forefront of the conversation within the American Psychological Association. We are focused on bringing together clinicians, researchers, educators, and policy makers to ensure this goal is met across all domains of practice. Join us and contribute to this conversation by submitting to one of our publications, posting on social media, participating in one of our committees, or running for a leadership position.

Join Us

You can become a part of the Division of Trauma Psychology today by registering online at:

www.apa.org/divapp

*APA membership not required

Join Division 56 Today!

Register online at:
www.apa.org/divapp

Contact us via email:
division56membership@gmail.com

Membership Category	Rate	Journal
☐ APA Associate/Member/Fellow	$45.00	Included
☐ Professional Affiliate*	$45.00	Included
☐ Early Career Psychologist	$24.00 Renew $45	Included
☐ Student with Journal	$24.00 Renew $34	Included
☐ Student without Journal	Free Renew $10	No

List-Servs

Members can join our list-servs by e-mailing listserv@lists.apa.org and typing the following in the body of the note: subscribe div56

LinkedIn http://linkd.in/10DflrT

facebook www.facebook.com/apadivision56

twitter @APADiv56

*Professional Affiliate Membership is offered to individuals who are not members of APA. Applicants must submit a description of professional training in trauma psychology or a related field, a c.v., and the name of a current member willing to provide a brief statement of endorsement. These materials should be submitted to the Membership Chair at division56membership@gmail.com

TRAUMA PSYCHOLOGY NEWS
An Official Publication of Division 56 of the
American Psychological Association

EDITORIAL STAFF

DIVISION 56
TRAUMA PSYCHOLOGY
AMERICAN PSYCHOLOGICAL ASSOCIATION

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

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

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

PUBLICATION SCHEDULE

Issue	Submission Deadline	Publication Date
Spring	March 4	Late April
Summer	June 3	Late July
Fall	September 10	Late October

ACCURACY OF CONTENT AND COPY INFORMATION

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

ADVERTISING POLICY, RATES, AND QUERIES

The appearance of advertisements and announcements in the TRAUMA PSYCHOLOGY NEWS is not an endorsement or approval of the products or services advertised. Division 56 reserves the right to reject, edit, omit, or cancel advertising for any reason. Advertising and announcements, as well as copy and artwork, must meet certain size specifications and be submitted in camera-ready form no later than the submission deadlines for the print issue desired.

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

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

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

DIVISION 56 LOGO INFORMATION

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