



# TRAUMA PSYCHOLOGY

## AMERICAN PSYCHOLOGICAL ASSOCIATION

### NEWS

#### Presidential Voice

*Carolyn Allard, Ph.D.*

As I sit here in my dining room to write, it strikes me that everything is very different than I had imagined it would be when I stepped into my role just a few months ago (which sometimes feels like an eternity). By “everything,” I mean *everything*. For one, instead of my office at the university, I am writing this from my dining room at home because: 1) pandemic, and 2) I needed a change of scenery from my bedroom desk. A more substantial departure from what I expected in writing this piece, however, is how I am feeling. I had imagined myself excitedly writing about the stimulating APA 2020 program we prepared for you, thanks to all the wonderful submissions and speakers, and about how much I was looking forward to seeing so many of you in DC. However, not knowing how things will play out is causing some chronic low-level unease that has somewhat dampened my excitement. While the convention is still technically on schedule to take place August 6-9, 2020, in Washington, DC, due to the everchanging nature of things, registration has been delayed until at least May 15 (for up to date information about APA 2020, visit the

convention website: <https://convention.apa.org/>).

I am still very enthusiastic about our program and am hopeful that it will be offered in some form or other, even if not in August, in person, or live. The theme for our APA 2020 Program and for my presidential year overall is Advancing Trauma Research, Practice and Policy through Reciprocal Collaborations. One of the primary aims is to increase cohesion and collaboration within our Division and within the larger trauma psychology community.

Unfortunately, over the past few years we have been experiencing increasingly polarizing discourses between different groups within trauma psychology, paralleling in some ways the increasing divisiveness we have been witnessing in our other communities and the greater sociopolitical state of affairs - indeed, the current pandemic has put a bright spotlight on how extreme the polarization has become. Therefore, in partnership with several other Divisions, we planned two keynote activities geared toward depolarization and

increasing effective reciprocal collaborations.

The first of these consists of a panel of leaders involved in the development of treatment guidelines and policies and in public discourses about the benefits and drawbacks of such guidelines. They will engage in a depolarizing conversation moderated by Mpho Tutu van Furth (co-author of *The Book of Forgiving* with her father, Reverend Desmond Tutu) and Venerable Thubten Jigme (psychiatric



*Carolyn Allard*

nurse turned ordained Buddhist nun), using international best practices like those used in the Truth and Reconciliation model and compassion engendering exercises. This conversation will not only assist us as a Division in being more effective in applying psychology to address the problems we are facing in the world today, but it will also provide a role modeling example of how we might transform divisive

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conversations in our other communities and settings.

The second planned keynote is a thinktank session with the aim of producing practical recommendations for decision making entities, such as research funding agencies, journal editorial boards, and policy change advocates, to develop policies and procedures that increase inclusive multidirectional collaboration between practice, research, education and policy advocacy. A panel of experts, whose work has effectively bridged across two or more of these sectors, beyond the more typical unidirectional research-informs-practice type of collaboration, will engage audience members in town hall style discussions.

Beyond the uncertainties about APA 2020 caused by the pandemic, I am also experiencing a more generalized emotional effect. This compels me to remind us all to be compassionate and patient with ourselves and those around us, and I hope that the interdivisional COVID-19 Taskforce we spearheaded will provide you with resources to be effective in your work and facilitate your self-care during these challenging times. The Taskforce is charged with developing resources that capitalize on our Division members' unique expertise, are specifically geared to our members' needs, and are not redundant to those already provided by [APA](#) and other organizations. Resources related to working with elderly populations, hospital workers, and secondary trauma, and working remotely with complex trauma, for example, are being added to the [COVID-19 Resources](#) page on our Division website as they are developed. Please also be reminded that we are here for one another. Take good care of yourself and let us know what you need.

## Clinical Psychology Postdoctoral Fellowship

### Clinical Psychology Postdoctoral Fellowship – University of New Mexico Hospitals, Health Sciences Center, Addictions and Substance Abuse Programs

The University of New Mexico Hospitals is accepting applications for a clinical postdoctoral fellowship in the Addictions and Substance Abuse Program. Appointment start date is August 1, 2020. For more information regarding this fellowship please review the attached advert.

#### Description

This is a 1-2 year post-doctoral training program that is tailored to the fellows' individual needs. The fellowship offers mentored clinical, research, program development, and supervision experiences with leading University of New Mexico faculty and staff in the areas of Substance Abuse and highly traumatized dual/comorbid populations. Fellows are mentored in a range of evidence-based interventions, integrated team approaches and consultation, evidence-based supervision practices, and program development / evaluation activities.

#### Eligibility

Candidates should have completed a doctoral degree in clinical, counseling, or similar field of Psychology from

an APA accredited institution, as well as completed an APA-accredited pre-doctoral internship. Candidates interested in a career with Health Sciences and/or Academic Medical Centers and/or specialization with substance use disorders and/or trauma exposed populations are encouraged to apply.

#### Compensation

Typical salaries range from \$50,400 to \$53,000 annual salary plus benefits. Total compensation is determined by the Hospital HR department at time of hire. Benefits include 10 paid holidays, 13 days of annual leave (vacation) and, if needed, 13 days of sick leave.

#### Applications

Provide (1) letter of interest; (2) current curriculum vitae to Larissa Maley, Ph.D. at [lmaley@salud.unm.edu](mailto:lmaley@salud.unm.edu)

Please address any questions, comments, or inquiries regarding the UNMH – ASAP fellowship program to:

#### Larissa Maley, Ph.D.

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*Jonathan M. Cleveland*  
Editor-in-Chief

## Editor's Note

*Jonathan Cleveland,*  
*Ph.D.*

The editorial team at *Trauma Psychology News* hopes this issue finds you and your loved ones safe and in good health. In the pages that follow, you'll find a wide variety of engaging content, beginning with a compelling and timely opinion piece, originally published in Spanish, from Dr.

Gonzalo Bacigalupe. Our feature this month is an empirical article from Cressley, Canady & Fugett-Fuller on prevalence of PTSD in rural EMS workers. Dr. Ani Kalayjian has sent a fascinating photo essay covering ATOP Meaningful World's recent trip to Armenia. Dr. Michael Eigen has provided us with a emotionally-compelling session excerpt, and Rachna Garg, with a heart-felt piece on working with women who have experienced miscarriage

The issue also contains four poems, each quite different in style and focus, as well as reviews of two books that would make welcome additions to traumatologists' bookshelves. In the student section, you find a review of TBI-related literature from budding authors Ignacio & Serpas. Finally, don't forget to stop by the Who's Who section to learn about up-and-coming Division 56 member, Dr. Rachel Wamser-Nanney.

In the coming weeks, if you find yourself with time and energy to create, we hope you'll consider composing something for *TPN*. We publish a diverse range of content; articles, letters, opinion pieces, project updates, announcements, poems and photo essays are all considered for inclusion. The deadline for our summer issue is Monday, June 8<sup>th</sup>, with publication slated for late July.

Best regards,  
-Jon

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# Coronavirus and Mental Health

Gonzalo Bacigalupe, Ed.D., MPH

It seems to me as if everyone is trying to understand what is happening, making decisions in the context of a crisis that affects all of us, but that few of us comprehend. There are people in self-imposed quarantine, while others remain skeptical without appreciating the importance of the situation, trying to live their lives as if this reality – a pandemic that is sickening and killing people in other countries – didn’t exist. No small proportion of people are obliged to and stressed out by having to travel across town to work, with a fear of contagion that grows day by day.

Understanding the mathematics of an epidemic is complicated because our cognitive framework allows us to intuitively grasp linear equations but not logarithmic ones. It is difficult to grasp exponential growth compounded by a series of uncertainties that don’t fit into a linear model. Epidemiological training such as the simulation of a tsunami alert entails continuous changes in information and the associated difficulties in appropriate decision making. This virus forces us to reexamine everything we think we know. Fear, anxiety and denial are common psychological reactions to these circumstances, reactions that can arise simultaneously or sequentially. Also, fatigue, symptoms of depression or dissociation, all interfere with the ability to think clearly, to act effectively, or to absorb information about the pandemic.

Trying to replace human contact with telework is not easy while at the same time dealing with all the tasks of home life. For the mothers of our country this scenario generates even more stress. For those who have to care for aging family members the stress is tremendous. We

therefore not only have to create asynchronous spaces (such as email, Whatsapp, Facebook) but also real-time ones to share our concerns and ideas about how to manage things going forward. These conversations with the community, family members, co-workers and others allow us to share strategies for simultaneously maintaining a physical distance and staying connected.

Preventing contagion should be our central focus. Right now there is nothing of greater importance. It is like a tsunami warning, where what is most urgent is evacuation to a safe location. The evidence regarding physical distancing from others is irrefutable and as of now is the only thing of which we are certain. In that sense, focusing conversation on treatment of the illness is relatively unproductive. We know that fear doesn’t necessarily lead to the best decisions. “Flattening the curve” is what is critical. Over and above the extent of the region affected by the disease, the crisis is fueled by the astronomical number of people requiring information, assistance, diagnosis, treatment and end of life care. Making the distinction between what is sensible and what is not is paramount. The mission of public health is to save lives and avoid having naturally occurring threats turn into disasters; this virus does not have to become a disaster.

**Preventing contagion should be our central focus. Right now there is nothing of greater importance.**

*Gonzalo Bacigalupe, EdD, MPH, is a professor of Counseling Psychology, at the College of Education and Human Development, University of Massachusetts Boston, and is an associated researcher at CIGIDEN in Chile where he leads research on disaster risk reduction governance and education, and he finds himself in quarantine*

## Social Media News

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



# Coronavirus y salud mental

## Gonzalo Bacigalupe

Académico UMass Amherst,  
máster en Salud Pública  
U. de Harvard  
Investigador Cigiden



Imagino a todo el mundo tratando de entender qué sucede, tomando decisiones en el contexto de una crisis que nos afecta a todos, pero que pocos comprendemos. Hay personas autoimponiéndose cuarentenas, otros escépticos sin darle importancia y tratando de hacer su vida como si esta realidad —una pandemia que está enfermando y matando gente en otros países— no existiera. Un porcentaje no menor de personas están obligadas y estresadas atravesando sus ciudades para trabajar, con la angustia de un contagio que crece día a día.

Entender las matemáticas de una epidemia es complicado porque nuestro aprendizaje nos permite entender intuitivamente las ecuaciones lineales, pero no las logarítmicas. Es difícil entender el crecimiento exponencial y sumar a ello una serie de incertidumbres que no caben en una ecuación lineal. También en el entrenamiento epidemiológico, parecido a la simulación de una alerta de tsunami, uno se en-

frenta a continuos cambios de información y a la dificultad de tomar decisiones apropiadas. Este virus nos obliga a repensar todo. El miedo, la ansiedad o la negación son mecanismos psicológicos frecuentes. Pueden ocurrir todos al mismo tiempo o en forma secuencial. También el cansancio, síntomas de depresión o desconcentración, todo lo cual hace difícil hacer otra cosa que no sea pensar, accionar o absorber información relacionada con la pandemia.

Intentar reemplazar el contacto humano con teletrabajo no es fácil, cuando a su vez se agregan todas las tareas del hogar. Para las madres de nuestro país este escenario genera aún más estrés. Para aquellos que tenemos que cuidar familiares de mayor edad es un tremendo estrés. Necesitamos por ello generar espacios no solo asincrónicos (*email*, WhatsApp, Facebook), también sincrónicos para compartir nuestras preocupaciones e ideas de cómo seguir adelante. Esas conversaciones con la comunidad, la familia, los colegas de trabajo y otros nos permitirán compartir estra-

tegias para mantenerse físicamente distante y a su vez conectados.

La prevención del contagio debiera ser el centro de nuestra preocupación. En este momento no hay nada más importante. Es como una alerta de tsunami, donde lo urgente es evacuar a zona segura. La evidencia acerca del distanciamiento físico con otros es irrefutable y es en este momento lo único en que estamos seguros. En ese sentido, el foco de la conversación en el tratamiento de la enfermedad es poco productivo. Sabemos que el miedo no necesariamente conduce a las mejores decisiones. “Aplanar la curva” es central. Inde-

pendiente del radio de enfermedad, la crisis se produce por la cantidad sideral de personas que requieren información, ayuda, diagnóstico, tratamiento y manejo de pacientes terminales. Ayudar a distinguir qué hace sentido y qué no es de suma importancia. La misión de la salud pública es salvar vidas y evitar que las amenazas naturales se transformen en desastres, y este virus no debe transformarse en un desastre.

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## APA Division 56 International Student Travel Assistance Stipend for 2020 APA Convention

To encourage international participation, the APA Trauma Psychology Division is providing a travel stipend to attend the 2020 APA Convention for international students who are (a) citizens of developing countries and enrolled in a graduate psychology program in their home country, or (b) enrolled in a graduate psychology program in the U.S., and who will be presenting a trauma related poster, paper, or a participant in a symposium or panel at the 2020 APA Convention in Washington, DC.

The travel assistance stipend consists of **\$1000 for travel expenses to the 2020 APA Convention**. Also included is a free one-year membership in the Trauma Psychology Division. This stipend is intended as partial support; matching grants or additional support from other institutions and organizations are also encouraged.

**Deadline for submission: May 15, 2020**

Please send a copy of your CV, the proposal abstract that was accepted for the APA convention, and your country of citizenship to Elizabeth Carll, PhD, Chair, Division 56 International Committee at [ecarll@optonline.net](mailto:ecarll@optonline.net)



## An Underserved Population: Rates of PTSD Among Rural EMS

Nicole E. Cressley, M.A., Brittany E. Canady, PhD,  
& April Fugett-Fuller, PhD

The estimated lifetime prevalence of PTSD among American adults is 8.7%, with women more likely than men to develop the disorder at some point in their lives (APA, 2013). The likelihood of developing PTSD is based on many factors, including the type of traumatic event and the characteristics of the individual (Lukaschek et al., 2013). PTSD is associated with serious physical and psychological consequences, and can result from numerous types of traumatic events (Atwoli, Stein, Koenen, & McLaughlin, 2015). The highest likelihood of developing PTSD is related to events involving interpersonal violence or military combat, and multiple exposures to traumatic events increase the risk for PTSD, putting populations like military personnel and first responders at a higher risk (Kilpatrick et al., 2013; Walker et al., 2016).

First responders include police personnel, firefighters, and ambulance personnel (Gonzalez, 2016; Regambal et al., 2015). These are the individuals who immediately attend to a scene of an accident, a crisis, or some other emergency. In comparison to research focusing on other first responder populations, the current literature fails to address ambulance personnel specifically. Emergency Medical Technicians (EMTs) and Paramedics are collectively referred to as Emergency Medical Services (EMS) personnel. Despite the fact that this subgroup spends the most time and is in the closest contact with injured survivors and relatives of the deceased, they are far less studied than firefighters and law enforcement (Marmar et al., 2006).

An even more specific subgroup worthy of clinical focus would be rural EMS workers. Generally, less is known about PTSD development and treatment in rural populations compared to urban counterparts (Erickson, Hedges, Call, & Bair, 2013). Rural communities are not immune to traumatic events. In fact, in rural areas, motor vehicle accidents have been estimated to be two-to-three times more likely to result in fatalities than in urban areas (Zwerling et al., 2005). Similarly, the rates of intimate partner violence have been shown to be significantly higher in rural areas compared to urban areas (Peek-Asa et al., 2011). To further complicate these issues, it is estimated that a third of the time,

rural EMS workers know the victim on the scene they are responding to (D'Andrea et al., 2004). Because of such unique issues, it is essential to consider the specific effects on rural EMS workers, which is what the present study sought to focus on.

Rural EMS workers throughout Pennsylvania and West Virginia were contacted through professional electronic listservs. A total of 437 participants finished an online survey comprised of demographic information, the Life Events Checklist for DSM-5 (LEC-5), the PTSD Checklist for DSM-5 (PCL-5), and the Barriers to Accessing Mental Health Care (BACE) Survey. On average, participants were 39 years old ( $SD = 12.3$ ) with 16 years of service as an EMS worker ( $SD = 11.8$ ). Most (68.7%) participants were male, and 31.3% were female. This demographic compares adequately to national averages of EMS personnel, with 68% male and 32% female (U.S. Department of Labor, 2016). This sample was limited in racial diversity, as 95.4% of participants were white. However, 82.1% of Pennsylvanians and 93.6% of West Virginians are white (U.S. Census Bureau, 2017). The largest group (43.2%) of participants were paramedics, 39.6% were EMTs, and the remaining 17.2% were in the "other job title" category. These responses included supervisory roles, directors, RNs, 911 dispatchers, ambulance drivers, and dual firefighter/EMS workers.

On average, participants scored a 24.6 on the PCL-5 ( $SD = 19.5$ ), with a score of 33 indicating a provisional PTSD diagnosis. Of the 437 completed PCL-5s, 35% were clinically significant, receiving a score of 33 or higher. Of the 35% with clinically significant scores, 96% endorsed at least one traumatic experience on the LEC-5 as "part of my job." No differences emerged between the PCL-5 scores for males ( $M = 24.21$ ,  $SD = 16.7$ ) and females ( $M = 25.52$ ,  $SD = 17.6$ ;  $t(416) = -.733$ ,  $P = .643$ ) in this sample.

Only 418 participants completed the BACE. The average BACE score was 65 ( $SD = 15$ ). Scores range from 20-100, with higher scores indicating higher perceived barriers to treatment. Out of the 418 respondents, 36.1% endorsed personal financial difficulties as a significant barrier in their communities. Following that, the items most highly endorsed as a significant barrier were: feeling embarrassed or ashamed to seek help (35.4%); worrying about help-seeking affecting their employment



Nicole Cressley

(33.2%); worrying about perceptions from family and friends (32.8%); and reluctance to acknowledge a problem exists (28.9%).

Based on the current diagnostic criteria for PTSD, occupational exposure constitutes a traumatic event (APA, 2013). This acknowledgment of the potential for traumatic events via occupational exposure has been justified in the present study, with most participants endorsing at least one traumatic event occurring as part of their job. Participants in the current study tended to endorse multiple traumatic events as part of their job, consistent with prior research that demonstrates multiple exposures in first responder populations increase their risk for developing PTSD (Walker et al., 2016). Thus, participants in the current study would appear to be at elevated risk of PTSD due to the types and number of events to which they are exposed as a function of their rural EMS work.

When examining rates of PTSD symptoms in the present sample, this elevated risk is evident; 35% had clinically significant PCL-5 scores. Prior studies have estimated the lifetime prevalence of PTSD among first responders at nearly one-third (Walker et al., 2016). Interestingly, the risk associated with EMS work appears to outweigh gender differences typically found in rates of PTSD diagnosis (APA, 2013). Although women are likely to experience intimate traumatic events in their lifetime, the LEC-5 revealed that the exposure to traumatic events as a part of the work of an EMS provider did not differ based on gender. Males and females appear equally susceptible to the development of PTSD in this role. It is therefore clear that serving as a first responder, and particularly as an EMS worker, substantially and independently increases risk of PTSD. Access to appropriate mental health care and resources to enhance resiliency and coping skills are essential to protect this vulnerable population. Despite this increased need, several barriers may limit access to this much-needed care.

In the current study, personal financial difficulties emerged as the most commonly cited barrier to mental health treatment. The average annual wage for EMTs and paramedics in Pennsylvania is \$33,200 and is \$28,320 in West Virginia, and both states are below

the national average of \$36,700 (U.S. Department of Labor, 2017). With 35% of the respondents reporting clinical levels of PTSD, there are likely other mental health issues occurring or co-occurring. EMS personnel are an extremely at-risk population who are traditionally underpaid and overworked in rural areas (Stamm et al., 2007).

While the current study identifies multiple risk factors associated with elevated rates of PTSD in EMS workers and substantial barriers to accessing treatment in this population, it is important to consider the key protective factors in rural areas which can be mobilized to assist in prevention and intervention strategies. Often, resilience is conceptualized from an individual standpoint, rather than a systemic one (Shaw et al., 2016). However, resiliency is highly dependent upon one's social environment, and rural cultures share characteristics that may be particularly beneficial. A unique component of Appalachian culture is the collectivist nature of the communal bonds which serve as a protective factor for mental health (Wagner, 2005).



*Brittany E. Canady*

While there are higher levels of adverse situations in Appalachia, individuals tend to report adequate well-being (Hamby, Grych, & Banyard, 2018). This resiliency could be due to the ability for Appalachians to find the meaning in a tumultuous situation. Higher levels of generativity are also quite common in rural areas. Generativity is the need to contribute to the younger generation, and this directly relates to the role of kinship ties as a protective factor for rural and low-income populations (Ostbye et al., 2018; Taylor, 2010).



*April Fugett-Fuller*

These protective factors should be used to mitigate the elevated risk for rural EMS personnel. Approaching prevention and intervention efforts from a systemic standpoint could be particularly powerful, rather than placing the expectation on the EMS provider to seek their own support.

Their occupational environment puts them at a high risk for adverse mental health outcomes, so that system should be incorporating more protective factors towards prevention. Rural EMS populations should be approached from a collectivist standpoint, meaning that intervention strategies should be targeted at the

group rather than the individual. With generativity in mind, peer support programs could be beneficial for this population.

Finding the meaning in an adverse situation can be highly beneficial. For EMS providers, a sense of meaning can certainly be tailored to their occupational experience through peer support. Focusing on the positive aspects of what they do can be a helpful way to cope with adverse situations and doing so with a peer reinforces a sense of shared meaning, addressing the need for social cohesion and kinship bonds. Because of the increased risk for this population, additional opportunities should be developed for better protecting EMS personnel and enhancing access to treatment.

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**Brittany Canady, PhD** is an Assistant Professor at Marshall University. She is board certified in clinical health psychology.

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## Falling Into Invisible Wounds

*Michael Eigen*

**Dan:** I've fallen down three times this week. I am beginning to wonder. Some moments I think there must be something wrong with my brain or my knees or hip or balance. Or maybe I am not paying attention. My head it somewhere else if it is anywhere at all. My mother used to say, "Danny, your head is in the clouds." I used to wonder what's wrong with me. Where is my head? I would look up at the sky and try to find it. What do you think?

**M.E.:** I'm not sure what I'm doing qualifies as thinking unless fantasy is also a form of thinking. I have read that it is but I also have read it is not. One author I read contrasted fantasy and dreaming, calling the latter thinking and the former a waste. But I am seeing a little child trying to learn to walk, falling down, picking himself up, stumbling, falling, trying again.

**Dan:** I can feel that – trying and trying, failing, trying again. Reminds me of Beckett's phrase, something like fail, fail again, fail better. But I don't think I am failing better. I think I am in danger of hurting myself badly. I am afraid of breaking.

**M.E.:** I can feel that. Can you say more?

**Dan:** The more that is coming is that I get up in order to fall. I am trying to fall. I am trying to lose my balance. Something does not want to stand.

**M.E.:** Something wants to break? Or get it touch with what already is broken?

**Dan:** That comes pretty close. Something broken. I try to break myself to feel what is already broken.

**M.E.:** Sometimes I think it is frustrating not to be able to fall forever. You fall and hit the ground, a limit. One keeps hitting limits.

**Dan:** Or limits keep hitting you. But there are other places. If I were an astral body I could fly or fall forever.

**M.E.:** Planet earth is awfully inconvenient that way, you keep bumping into things. You keep bumping into yourself.

**Dan:** When I was little – maybe three, four, before I went to school - I was alone a lot.

**M.E.:** All by yourself without anyone around or do you mean you felt alone. And if so, when did you feel alone most? Least?

**Dan:** No – I mean all alone by myself. My father worked and my mother would leave me all alone in our apartment and she would go out and do things. Sometimes I cried or played. And sometimes I would look out the window and see things – strange things, some of them flying in the air, some climbing up the building. I realized there was something wrong – wrong with me. With my own mind. Something wrong and no one could help me. When I was much older and learned the word trauma in high school and college I would think that's it, that's what I have, and named it the trauma of aloneness. Can aloneness be a trauma or did I make this up? The aloneness of trauma.

**M.E.:** If you are making this up it is still something to pay attention to. It sounds like something you really feel – really felt.

**Dan:** Are feelings reality?

**M.E.:** Deeply so.

**Dan:** When I was growing up feelings were something to laugh at, make fun of, unless I fell down and felt hurt, if there really was a wound someone could see and take care of. Sometimes I wondered if I really hurt myself more, like falling out the window or down the steps – wouldn't that cause alarm? Wouldn't that be real?

**M.E.:** And what about invisible wounds that no one could see, that only you could feel?

**Dan:** (Beginning to weep). I feel like crying, but am so angry that this could be true. Can there be angry tears? Angry and sad tears at the same time?

**M.E.:** For all the wounds one thought were not there, that were unreal. Are we sensing together that sometimes wounds that can't be seen can be more real than those that can?

**Dan:** More than sometimes. [A long pause, tears]. Wounds are crying.

**M.E.:** Tears visible as well as invisible.



*Michael Eigen*



**Dan:** Do you feel these things too? Do you have wounds that can't be seen?

**M.E.:** I have a hunch you can see some when you look at me.

**Dan:** When I hear you too, your tone can make me feel the wounds within. I used to be afraid to feel this. I felt I would never come back. I'd be swallowed by whatever my mother meant by clouds. Clouds are hungry for wounds. Wounds hide in clouds.

**M.E.:** And now?

**Dan:** I feel I'm feeling a little more, a little bit more what I've been afraid of feeling since I was little. Not just afraid but not knowing how. Not learning how to feel what can't be felt but makes you tighten around it. This must be what people mean by being haunted. I am a haunted house and you are too.

**M.E.:** It is good to air our ghosts together, at least a little.

**Dan:** A little – a little relief, a little opening. My breathing feels more relaxed. I didn't know it was tight.

**M.E.** Maybe there'll come a time when you won't have to fall down so much to contact yourself. Maybe you can find other languages besides injury.

**Dan:** Yes, I think that's what we're doing now, the two of us.

*Michael Eigen, PhD is author of twenty-seven books and many papers. He teaches and supervises at New York University Postdoctoral Program in Psychotherapy and Psychoanalysis and the National Psychological Association for Psychoanalysis. He has been Editor of The Psychoanalytic Review, received the Lifetime Achievement Award from the National Association for the Advancement of Psychoanalysis and Hans Loewald Award from International Forum of Psychoanalytic Education. He gives a private seminar on Winnicott, Bion, Lacan and his own work ongoing forty-five years.*

## The Impact of Miscarriages: What Women Need in Order to Heal from the Trauma of Losing a Child

Rachna Garg, MA, AMFT

### Miscarriage Stigma

Women carry a tiny little human being for approximately nine months, with the hope that maybe one day that tiny being will have a joyful and prosperous life. But what about women that lose that chance? What about their dreams and hopes for their baby? What about the men that may never get a chance to become fathers?

According to the American Pregnancy Association (2019), 10-25% of pregnancies end up in miscarriages; that is as many as one in every four pregnant women that may lose hope, gain a hole in their heart, and potentially be forever scarred by the pain of losing a child that they immediately fell in love with but that never came to be. The loss felt after miscarriage, along with potential previous psychiatric illness, childlessness, lack of social support, marital challenges, and uncertainty about future pregnancy, can create compounding psychological distress for women (Isguder et al., 2018).

Some in our society treat miscarriage like a cold that will eventually go away, rather than for the trauma that it is. "You'll get over it," "it's so common," or "you'll get pregnant again," are statements women, like me, have experienced after losing their baby. As a result, blame,

guilt, and shame are some of the emotional experiences women may encounter, rather than feeling supported and encouraged. A study of Israeli women who miscarry found that they often feel they are somehow defective, abnormal, or that they have failed in fertility, becoming inadequate wives. (Epstein et. al, 2009)

I find that people forget that miscarriage is not a choice; it is a tragedy that shatters dreams in an instant. One minute you have your life planned out with a tiny baby growing inside of you and the next minute, it's over. As a community, we need to come alongside people that are suffering from miscarriages and be of support. We need to empathize, empower and engage instead of ignoring, forgetting and blaming.

### Empathize

When I had lost my first baby at just 12 weeks, I remember the shock my body went through. I was numb one minute and the next I wanted to cry my eyes out. I wanted to find someone who would understand what I was going through and tell me that I was not alone in this pain. I was scared, devastated and ashamed of myself. I wanted someone to tell me, "Hey, I've been there; I know the pain you're going through. Let's walk this road together," or for someone to just sit with me in silence even if they did not understand my pain. But all I heard was, "You'll get over it," "It happens to many women," and "Get

busy doing things and that will make you forget this happened.” Or people just didn’t mention it at all, as if my pregnancy never even existed. My second and third miscarriages were met with the same response, with little empathy.

Oftentimes, people who have gone through miscarriages may have numbed their feelings, or would rather not talk about the experience, as if it were taboo. Many times, I have heard the statement, “It is in the past, let’s just move on.” I understand that, but no matter how long ago it was, it is still trauma that stays with us. That pain may be triggered when we attend a baby shower or see a mother taking her child for a walk. For me, every time I saw a pregnant woman, I wondered what was wrong with me, that I couldn’t hold on to a pregnancy. The triggers can occur years after the miscarriage happens. Instead of forgetting, we need to walk in this together. Here are a few ways to empathize with people who have gone through a miscarriage:



*Rachna Garg*

- Sit with them in silence. Sometimes, all we need is someone to sit with us in silence. You don’t have to understand what they are going through but your willingness to allow them to just “be” is powerful enough.
- Ask yourself, “What if this was me, losing my child? What would I need?” Putting yourself in their shoes can help you have more empathy rather than just offering sympathy which is helpful but lacks support.
- Don’t ignore their pain but walk with them in it. You might consider being open to crying with them, holding their hand, or otherwise being as present as possible so they know who to lean on when feeling hurt. Remember, this is a devastating loss for them, and they may have lost all hope in ever becoming a parent again.

### Engage

Being actively engaged with people who have suffered such trauma is crucial, so they do not feel alone. The more you’re willing to be present and spend time with them, the healthier their healing will be. Having high levels of support in their lives during this time is very important. The saying, “Out of sight, out of mind” should not apply to women and their partners, who have experienced miscarriages. When people are going through a miscarriage here are a few things you can do in order to help engage with them in a loving and compassionate way.

- Allow them to talk about their pain. Let them feel comfortable and safe around you so that they don’t have to ignore what happened but rather be able to express their feelings about it.
- It is okay to not understand what a person who has suffered from a miscarriage is going through. Let them know that you’re there for them even if you can’t understand their pain. Sit with them, cry with them, hold their hand...just be there in any way you can. Walk with them each step of the way so that they feel the support and love from you.
  - Never make them feel as if they are the ones to blame. Women who have suffered from miscarriages have already blamed themselves in more ways than one so let’s not add to their guilt and shame. Instead let us EMPOWER them.

### Empower

Women who go through the physical pain of having a miscarriage often forget to take care of themselves. They become numb, angry, sad, and frustrated with themselves. They don’t realize that their bodies have just gone through trauma and it takes time to heal from it. It is essential for them to understand that it will not only take time for their bodies to heal physically but it will also take time for their heart to heal as well. Empower them by addressing the subject of self-care in a gentle, loving manner. Encourage them to do the following:

- Do something each day that will make you happy such as taking a walk outside on a sunny day, going to the beach, eating your favorite dessert, etc. The point is to do things that put a smile on your face, even if it’s for a moment.
- Cry so that your body can release the pain. Cry with a friend, your partner, by yourself; but don’t repress any feelings that need to come out and be released. The pain of losing a child will never go away, but crying will help you release pain.
- Write your feelings in a journal and then let them go. Write a letter to your baby that will forever remain in your heart. Do what feels best in order to keep moving through the pain.
- Spend time with loved ones. Have coffee with a friend, lunch with a relative, etc. Don’t isolate yourself from others but rather engage with them as much as possible.
- Take care of your body with physical activity such as exercising, yoga, going for walks, etc. Take baths, rest when needed, and focus on yourself both emotionally and physically.
- Educate others in how they can be of service to



you. Ask for help when needed, and don't be ashamed of how you're feeling.

Being part of grief groups for miscarriages can be immensely helpful, as this form of trauma is unique, and perhaps can only be fully understood by others who have experienced this type of loss. The pain of losing a baby is enough to make us feel empty and hopeless. Having groups may help people form a community of support. There is deep healing that happens when people help and support one another.

### Keep Moving Forward

I am barely touching the surface on how we can help women that have gone through the pain of miscarriages. Post traumatic growth may be an important experience for women seeking to find peace and become resilient after such trauma. As stated in the 5<sup>th</sup> edition of the Diagnostic and Statistical Manual for Mental Disorder (DSM 5; American Psychological Association, 2013), the diagnosis of persistent complex bereavement disorder (PCBD) has symptoms of continued longing for the deceased (in this case is the baby that was never born). Such bereaved women may suffer from intense sorrow, bitterness, shock, numbness, anger, social disruption, detachment from others, confusion in understanding why the miscarriage happened, and feeling a loss of one's identity (Boelen & Prigerson, 2012).

This is not a subject matter that should be hidden, it is one that needs to come out of the shadows and achieve greater acknowledgement of in our society. The saying, "out of sight, out of mind," should not be applied with

women who have gone through miscarriages; we need to sit with them, talk with them, and engage in helping them heal through the loss by offering love, support, and compassion.

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## Invitation to Division 56 Fellows

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



# 2020 Humanitarian Mission to Armenia Launching Suicide Prevention Lifeline Summary

Nanar Nakashian, Dr. Ani Kalayjian,  
Dr. Justina Medina

We planned to return to Armenia with several goals to be accomplished, including the launch of the very first Suicide Prevention Lifeline in Armenia and the very first Psi Chi Chapter in the Caucasus.

October 2019 team members of the Association for Trauma Outreach and Prevention (ATOP), MeaningfulWorld Armenia Mission consisted of Dr. Ani Kalayjian, Justina Medina, and Nanar Nakashian. Our MeaningfulWorld Armenia coordinators were Lara Abrahamyan and Karen Gargaryan. This year, Lorraine Simmons will join Dr. Ani Kalayjian.

Our first day of the mission began at the Academy of the Ministry of Emergency Situations where representatives from the Psychological Department of the Ministry of Emergency Situations enthusiastically greeted us. There were promising discussions of collaborations and of what MeaningfulWorld has to offer, such as trainings on emotional management and meaning making. Later in the day, we had 80 students actively participate in our workshop at the Pedagogical Institute on the generational impact of trauma and approaches to post-traumatic healing. The day continued at the Psychology Department at the Pedagogical Institute. Over 65 students were very excited about the 7 Step Integrative Healing Model and Soul-Surfing. We concluded the day with the celebration of World Mental Health Day at the Yerevan State University and with the launch of the first Suicide Prevention Lifeline in Armenia. Additionally, we launched the Armenian translated

publication of Dr. Kalayjian's book, *Forget Me Not*.

On Day 3, the team helped celebrate Yerevan State University's 100<sup>th</sup> anniversary. We were invited to participate in the 7th International Conference on the Current Issues in Theoretical and Applied Psychology, where Dr. Kalayjian shared how to transform tragedy and trauma into healing and meaning making. Dr. Harold Takooshian presented on International Psychology, and both Drs. Kalayjian and Takooshian introduced their efforts to establish the first Psi Chi Chapter in the Caucasus at Yerevan State University in collaboration with Dr. Hrant Avanesyan

On Day 4, the team went to Yerevan State Medical University, Department of Medical Psychology, where we conducted a training on the 7 Step Integrative Healing Model, EQ (Emotional Intelligence), and how to heal the mind, body, and spirit holistically. Participants consisted of psychiatrists and psychologists. We also had the opportunity to discuss the benefits of EMDR and provide supervision with a small group of professionals who were trained 20 years ago with our volunteer

Dr. Gergerian. The team spent Day 5 at the closure of the International Psychological Conference at Yerevan State University with a workshop, later celebrating the establishment of the Pan-Armenian Psychological Association. We concluded the day with a moving experience at Megerian Carpet Museum and Cultural Center in Yerevan. We thank Karen Ayvazyan and John D. Megerian for their collaboration on the establishment of the Suicide Prevention Lifeline.

On Day 6, we started at Article 3, an equal rights center, where we conducted suicide prevention training with volunteers. This experience was very meaningful









because we got to address causes of the rise of suicide in Armenia. In the afternoon, we were invited to by Dr. Gevork Poghosyan, to the National Academy of Science Institute of Philosophy, Sociology and Law, where Drs. Kalayjian and Takooshian presented on 30 years of collaboration with the Academy. At the invitation of Dr. Khachig Gasparyan, we ended the day at the American University of Armenia (AUA) and facilitated training (the only workshop in English) for his psychology class. The university students were curious and had a wonderful discussion about trauma, PTSD, and suicide prevention.

The team began Day 7 in Vanadzor, located about 80 miles north of Yerevan. We conducted training at the Town Hall with around 65 police, psychologists, judges, lawyers, and other professionals. The group was lively and very interested in the discussion around mass trauma. We then had the honor to meet with his holiness, Archbishop Sebouh Chouldjian of Vanadzor, at his invitation. Thereafter, we conducted training at Vanadzor State University on mental health and trauma healing. An essential part of our training included suicide prevention skills, which were requested by the community. We concluded the day at The Vanadzor Children’s Home, a heartwarming experience where the children were all incredibly curious and friendly. We met with 38 children from ages 2 to 19, bringing them many donations including toys, crayons, clothes, and flower remedies for emotional healing.

We started Day 8 with a meeting at UCom in order to secure a phone line for the suicide prevention

lifeline. We continued our day at the APAGA Center for Psychological Services, where over 65 volunteers gathered for training on the Suicide Prevention Lifeline. There was a heated discussion regarding domestic violence, which is an ongoing challenge in Armenia. Unfortunately, about 60% of the volunteers had seen or experienced domestic violence, which is very much a part of the ‘culture’ in Armenia. We challenged the volunteers to think about their own health and not “what others will talk about.” Societal peer pressure governs decisions to stay in an unhealthy and abusive family, and we encouraged them to make a change. A male participant asked curiously, “So are you saying that the choice is divorce? And what about family values?” We reinforced that family values need to be protected by both partners, without expecting that the women have to suffer domestic violence to keep the family together.

Day 9 began in Gyumri, the second largest city in Armenia, in the Shirak province, where we had a productive morning at Shirak State University. Sixty students of psychology and sociology, along with faculty and deans participated in our workshop. They learned about the five different types of trauma as well as the 7 Step Integrative Healing Model. When asked about what worried them, a majority shared that they worried about the political unrest in Syria and the economy in Armenia. Afterward, we conducted a training for INTRA-PSY-CLUB, an association for psychologists, and another training for the young female members of the Nor Luyce program, where they receive mentorship, counseling, and real-life skills. We concluded our day with a visit to Our Lady of Armenia children’s





orphanage and technical school. We had a special visit with the orphans there, during which we taught them about lifting each other up from distress through our campaign “Lift one another up, and don’t be a crab in the bucket.”

We began Day 10 at the Ministry of Emergency Services. After being greeted with a very warm welcome by Haykuhi Gharibyan, Dean of the Academy of the Ministry of Emergency Services, we met the Major General Matevosyan of the Academy. We then conducted a workshop with over 55 participants, which covered various types of trauma, the 7 Step Integrative Healing Model, and suicide prevention.

We accomplished a great deal in 11 days. We directly reached 575 people and indirectly reached over 2,000 people. We conducted 19 trainings in three different cities and collaborated with three ministries, one high school, six NGO’s, and two orphanages. We received touching feedback from various participants who called



us “true angels,” striving to change the world through our work. It is heartwarming to see people open their hearts and show affection after our trainings, hugging as if they do not want to let us go. We must mention how the beauty of Armenia itself is heartwarming, truly unique, welcoming, and feels like a home away from home. As Nanar said, “Armenia is a feeling, not a place,” while Justina added, “Armenia feels like it is a country out of a fairytale. It is hard not to fall in love with Armenia.” Everyone we met and collaborated with was so wonderful, welcoming, insightful, and intelligent. It was truly a blessing to have the opportunity to serve and work in Armenia. We were delighted to be able to sponsor three orphaned children, Nune, Vachagan, and Hovhannes.

Special gratitude to our collaborators in Armenia: Dr. Hrant Avanesyan, Karen Gargaryan, Lara Abrahamyan, Dr. Gevork Poghosyan, Gevork Manoukian, Dr. Khachig Gasparyan, Shogher Mikaelyan, Kristina Baghdasaryan, Sister Serpouhi, Nayra Avedikyan, Kristina Torosyan, Tatevik Arakelyan, Karen Ayzazyan, Haykuhi Karibyan, Lilia Abrahamyan, Hayrabet Keheyanyan, Arevik Yeritsyan, UCom, and all other volunteers who will be helping on the suicide lifeline.

A warm, heartfelt gratitude to our team: Dr. Ani Kalayjian, Dr. Justina Medina, and Nanar Nakashian, as well as to all our collaborators and donors.

**Remember:** When one helps another, both become stronger.



## Book Review:

# *Healing Sexually Betrayed Men and Boys: Treatment for Sexual Abuse, Assault, and Trauma*

by **Richard B. Gartner, Ph.D.**

(2018) New York, NY: Routledge, 344 pages, \$48.95 paperback

Reviewed by **Lisa Y. Livshin, Ed.D.**

This is a remarkable book and an important read for those of us who work with boys and men who have experienced sexual trauma. It brings together twenty-one trauma experts to address a range of issues that, together, help us better understand the broad impact that childhood sexual abuse (CSA) and sexual assault have on males. Clinical vignettes serve as powerful teaching tools to illustrate how trauma is expressed at different junctures in healing.

In each chapter we are reminded of the common societal belief associated with male sexual abuse and the one which most complicates men's healing. It is the belief that men cannot be sexual victims, the premise of *Male Rape Myth*. Simply put, it assumes that men should be able to fight back and protect themselves. As clinicians specializing in trauma, we often see that the deep shame exhibited by male sexual abuse survivors is often in large part due to the inability to fight off the perpetrator - to somehow prevent the assault. Male shame over sexual victimization is a hallmark throughout Gartner's thoughtfully edited book.

We learn that a staggering number of men are sexually assaulted in the Armed Forces. The shame that victims experience is intensified by the hyper-masculine culture of the military. Veterans' recovery from Military Sexual Abuse (MSA) is complicated. Start with the trauma of sexual assault and add the factor that your perpetrator is higher in command than you, and the person to whom you would report an assault. Or consider having multiple perpetrators with whom you must share sleeping quarters. Hazing rituals and homophobia make it difficult to report abuse, contributing to feelings of helplessness, shame, self-blame, and anger.

We read about "Weekend of Recovery" retreats where men begin to feel safe around other men and share their abuse experiences. A model for retreats is outlined and the reader gets a sense of how powerful and healing it can be for men to have the opportunity to speak about

their trauma and lessen their shame when they can feel compassion for other male abuse survivors.



*Lisa Y. Livshin*

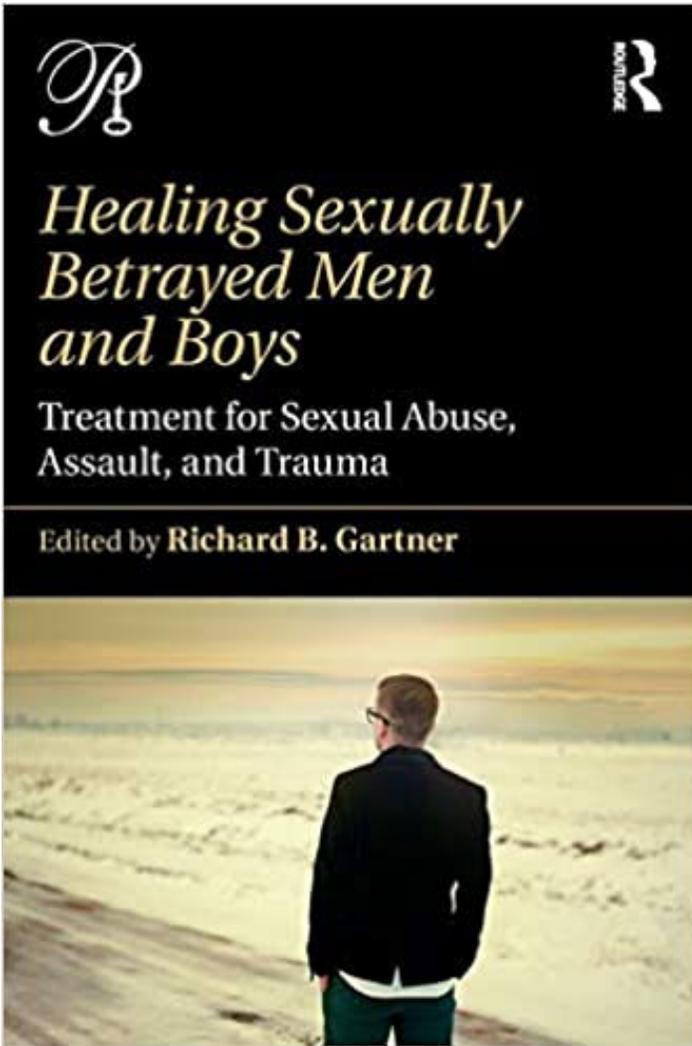
The sexual assault of men is highly under-reported. While reading this book, we see more clearly the history of not talking about male sexual assault. It is difficult for our society to accept that men can be victims. Nowhere was this more apparent than in Rick Goodwin's chapter on the demise of a Canadian trauma organization which focused on providing services to male sexual abuse survivors.

We know that male sexual trauma can lead to shame, confusion, secrecy and self-blame - all of which can result in attempts to numb these intolerable feelings. It is so important that Gartner included a chapter on PTSD as a psychiatric co-morbidity to substance abuse. It helps us understand the delicate balance of discussing sexual victimization while in recovery and how not numbing trauma memories leaves survivors vulnerable to relapse.

The chapters on sexual abuse of young boys and covert seduction (rarely discussed), help us further comprehend the antecedents of trauma behaviors in males. Powerful therapy vignettes could be especially useful to beginning child trauma therapists; to help them learn about changing self-states, traumatic reenactment, and attachment issues. Concluding chapters on dual histories of being a victim and a perpetrator help us not to vilify these men, but to better understand the challenges involved with treating them.

As a clinician working with boys and men who have experienced sexual trauma, this was the first book I have read that covered the many intricacies of working with this population. Gartner includes the entire constellation of working with male survivors. We read about them in the context of childhood, community, intimate relationships, therapeutic groups, and the military. I would have welcomed the addition of a chapter on clergy abuse, which is lacking sufficient recognition in the male sexual trauma literature.

Lastly, the brief but powerful chapter "The Heart of the Matter" written by Mikele Rauch, a female therapist who works with male survivors, expertly captured the



push-pull of doing trauma work with men. The process of a female therapist and a male patient achieving a sense of safety in a therapeutic relationship, while traversing the patient's vulnerability, shame, sadness, and anger, is the most authentic account of working with betrayed men that I have read.

*Dr. Lisa Y. Livshin is a licensed psychologist in Massachusetts and Florida who specializes in the evaluation and treatment of trauma. In addition to private practice, she serves as a legal consultant on sexual trauma cases. Since 2006, she has been on the Steering Committee of the Massachusetts Disaster Resource Network and is currently the Boston Metro Region Team Liaison. Her prior experience includes 27 years as a trained and certified American Red Cross disaster mental health provider. From 2011-2014, she was an Adjunct Professor of Psychology at Lesley University Graduate School of Psychology where she taught Disaster Mental Health and Community Crisis Intervention. Since 1987, she has been a Clinical Instructor in Psychiatry at Tufts University School of Medicine.*

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



# Book Review: *Exploring the Landscape of the Mind: An Introduction to Psychodynamic Therapy*

by Janet Lee Bachant, Ph.D.

(2019) New York, NY: IP Books, 223 pages, \$35.00.

Reviewed by Kenneth Barish, Ph.D.

Beginning psychotherapists face a daunting and unsettling task. Patients consult us for varied and complex problems – an amalgam of acutely painful feelings, chronic self-doubt, recurring anxious and depressed moods, traumatic life experiences, self-destructive behaviors, and unsatisfying personal relationships - that they have often lived with for many years. As therapists, we need to decide, from among the many things that patients tell us, what are the origins (and persistence) of their difficulties in living? What kind of understanding can I offer? Where do I begin? What do I say?

Janet Lee Bachant has written an excellent introduction to a psychodynamic understanding and therapeutic approach to these clinical problems. *Exploring the Landscape of the Mind* is not a dry recitation of theories and controversies in psychoanalysis or psychotherapy. Bachant wants to teach us to be better therapists, and she succeeds admirably. Throughout the book, she pays special attention to the problems of working with patients who have suffered complex developmental trauma. Her understanding of trauma draws from important clinical and neuroscience research (Van der Kolk, 2005; Ginott, 2015).

For Bachant, psychodynamic therapy is defined by our commitment to understanding patients' inner experience and our effort to facilitate the emergence of latent meanings and unconscious processes. She begins with a review of the fundamental values that make therapy possible. Most of these values are universally acknowledged as essential requirements for all psychotherapy, the shared humanistic foundation of our work: valuing the influence of the past, respect, curiosity, non-judgmentalness, empathy, genuineness, the ability to accept limits, flexibility, courage, hope, the creation of a setting of safety, and the importance of psychotherapy as a collaboration.

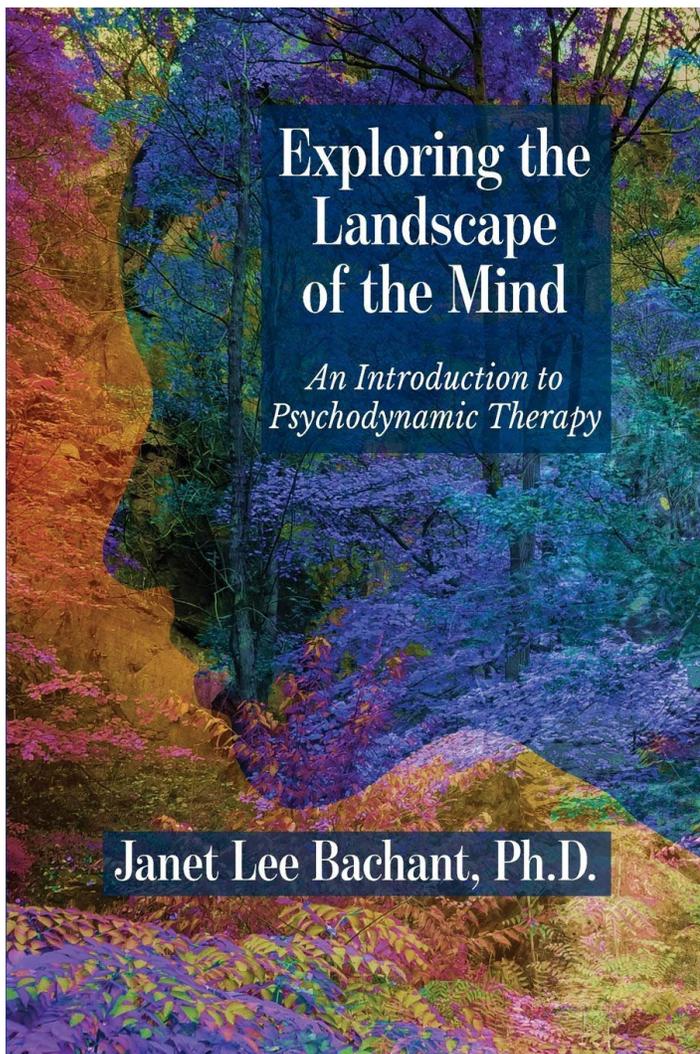
Bachant explains the basic frame of the therapeutic relationship in psychodynamic psychotherapy – an invitation and encouragement of free association by the patient (a rare form of emotional honesty) and the neutrality of the therapist. The therapist's neutrality (often misunderstood) protects the therapeutic process and "holds the treatment through the stresses and storms of analytic work." She offers an understanding

of essential psychodynamic concepts: fantasy, transference/countertransference, resistance, and multiple functioning. Bachant defines each of these concepts broadly, not only as they apply to the unique setting of psychotherapy, but as basic principles of mental life. Fantasy, Bachant teaches, is an organizing activity of the human mind and a "window to our soul." Transference and resistance are also defined broadly. Bachant emphasizes the adaptive function of resistance, a "guardian of psychic equilibrium," useful and necessary at an earlier time in patients' lives, "to be welcomed rather than dreaded, 'befriended' rather than pushed away."

Bachant then provides an organizing framework for listening from a psychodynamic perspective. These chapters are perhaps the most original contribution of the book. For Bachant, psychodynamic listening is "fundamentally listening with the heart." She identifies seven modes of therapeutic listening, what she calls "listening for the footsteps of the past." These are: listening for content; listening for feeling; listening for defense; listening for organization; listening for transference/countertransference; listening for meaning; listening for enactment; and listening for organization. Bachant's description of these modes of listening (and her practical advice) will be enormously helpful to beginning therapists, enabling them to hear "many layers of meaning in *how* patients communicate with us," forms of communication that are continuously and simultaneously present in the therapeutic interaction.

In a final section, Bachant offers clinical wisdom about the effect of trauma on development ("like a virus that invades the body's cells") and how to help patients change their relationship to childhood trauma and adversity – by learning to identify triggers, develop a new narrative of trauma, and take more effective action in their lives. She wisely notes that change comes in small steps and helps us recognize and encourage small changes that patients make in how they relate to their feelings, new ways of relating to self and others that minimize the power of emotional hijacking.

Throughout the book, Bachant is non-dogmatic and quietly, but persuasively, integrative. She warns us against simple generalizations and one-dimensional understanding. She is able to capture the complex, multi-layered nature of the therapeutic interaction, and she avoids the (usually false) dichotomies that are so common in our field. Bachant's understanding of psychotherapy is guided by the principle of multiple function: "As we do psychotherapy, we need to keep in



mind that every action, every thought, every feeling, every experience a person has is determined by multiple forces“ and “when it comes to explaining human experience, every understanding is by definition a partial understanding. *Exploring the Landscape of the Mind* is a book of “both/and” not “either/or.”

I have some differences of emphasis from Bachant in my understanding of therapeutic listening and mechanisms of change. Bachant recognizes the importance of empathy (which she traces, as do many others, to nonverbal communications between mothers and infants) and her therapeutic work is deeply imbued with empathy. She expresses some caution, however, about the danger of over-identification with patients, “where the boundary between patient and therapist blurs.” Although this concern is appropriate, I would place greater importance on empathy, both as a mode of listening and as a profound therapeutic process in its own right. Empathy is continuously present in therapy, guiding the therapeutic interaction in both large and

small ways, not only in our direct empathic statements to patients, but also in the subtle, often unconscious, adjustments we make in response to patients’ nonverbal communications. Empathy is our therapeutic GPS, letting us know when we have taken a wrong turn or gone subtly off course (Barish, 2018). I would also have liked even more discussion of listening for feeling and the centrality of affect in the therapeutic process. (See, for example, Zellner et al., 2011, on emotions as “command systems” of the mind, and Lotterman, 2012, on affects as “a psychological center around which... other elements... are organized, like a force field.”)

These small differences, however, do not diminish my enthusiasm for what Bachant has accomplished in this book. Bachant has done a great service to the field of psychotherapy, including non-psychodynamic psychotherapy. Any therapist, *of any persuasion*, who reads this book will be a better therapist. *Exploring the Landscape of the Mind* should be read by students at the beginning of their training as well as by experienced therapists, when we need to take a step back and reflect on our daily clinical experience, and refocus our attention on overlooked aspects of the complex, challenging, and compassionate work that we do.

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# Lost in Translation: A Call to Action Addressing the Disparities in Postinjury Rehabilitation for Community-Dwelling Survivors of Traumatic Brain Injury

Daniel A. Ignacio & Dylan G. Serpas

Traumatic brain injury (TBI) is the leading cause of death and disability among all trauma-related injuries in the United States (U.S.; Center for Disease Control [CDC], 2019). Despite being a rising public health concern, there remain considerable treatment disparities between survivors' rehabilitation needs and service provision. Falls and motor vehicle accidents are leading causes of TBI within the U.S. (CDC, 2019), including among the survivors of TBI who live in community settings outside of medical and military facilities, the largest population of survivors (Vanderploeg et al., 2019). Despite the high incidence of community-dwelling TBI, disproportionate empirical attention is provided to athlete, military, and veteran populations. For example, armed service members are eligible to receive community-integrated rehabilitation services across the 21 defense and veterans brain injury centers in the U.S., and greater public focus is provided to sports-related TBI in pediatrics relative to fall-related TBI in older adults (Taylor et al., 2017).

TBI may result in disturbances in cognition, emotion, behavior, and physical functioning, yet symptoms related to cognitive and affective sequelae may be underlying chronic difficulties in successful adaptation. TBI symptoms can impact reintegration into school, work, and social domains, areas salient to community-dwelling survivors. Many survivors report post-concussive symptoms (e.g., memory difficulties) that may resolve within three months to a year (Belanger et al., 2005). However, half of the cases may experience persistent symptoms for years following the injury (Theadom et al., 2019). Patients with TBI, psychiatric complaints, and impaired cognitive functioning at discharge are at the highest risk of long-term unemployment.

The U.S. unemployment rates among TBI survivors two years post-injury may be as high as 60% for full-time unemployment and 35% for part-time employment (Cuthbert et al., 2015). TBI is a chronic, life-long condition increasingly conceptualized as a disease process rather than a discrete injury, given its

irreversible sequelae (Masel & DeWitt, 2010) and its association with adverse outcomes such as homelessness (Stubbs et al., 2019), incarceration (Durand et al., 2017; Schofield et al., 2015), and substance abuse (Center for Substance Abuse Treatment, 2010; Corrigan et al., 2012). Consequently, survivors face the possibility of mismanaged symptoms following emergency department discharge, given a reduction in the length of time monitored by physicians (CDC, 2019). Currently, unstandardized assessment complicates identification, symptom management, and rehabilitation outcomes.



Daniel A. Ignacio

## TBI Assessment

Correctly and comprehensively identifying the source and impact of TBI-induced deficiencies is critical. TBI is accompanied by a breadth of neurologic signs and symptoms, which are captured using medical and psychiatric classification systems. Medically, TBI is classified from mild to moderate to severe according to loss of consciousness and post-traumatic amnesia (CDC, 2019). This

classification system does not capture the range of neurobehavioral symptoms experienced. For instance, survivors with mild and severe TBI may express similar affective and cognitive symptom profiles, even though they may be categorized on opposite ends of the severity spectrum (Ruttan et al., 2008). Additionally, measuring severity is unstandardized and is currently accomplished by using a variety of assessments (e.g., OSU-TBI ID, BSIQ, Glasgow Coma Scale). This measurement variability has affected current TBI incidence estimates. Regrettably, 20% to 30% of the estimated two and a half million emergency department visits that were classified as *unspecified head injury* had sufficient evidence to fit a formal TBI diagnosis (CDC, 2019).

In addition to the medical categorizations (i.e., mild, moderate, severe), there are mental health categorizations that may better describe associated functional deficits. These include mild and major neurocognitive disorder due to TBI (American Psychiatric Association [APA], 2013). In addition to cognitive complaints, survivors may also experience affective symptoms including emotional dysfunction, changes in personality or mental health problems such as post-traumatic stress, depression, or anxiety (Arciniegas & Wortzel, 2015). Estimates of depression

and anxiety among survivors are approximately 61% and 70%, respectively, with co-occurrence in approximately 75% of cases (Ponsford et al., 2016). Further, affective and cognitive symptoms can influence each other, complicating the ability to effectively treat symptoms. This relationship is a dysfunctional feedback loop, such that cognitive symptoms co-occur with pain or emotional factors, which engender secondary cognitive complaints (Kay et al., 1992). Observable disparities in empirical definitions and assessment of the condition across the literature have created an impending need for reliable and evidence-based treatments to inform clinical practice guidelines.

### TBI Treatment

Many existing medical interventions for TBI (e.g., steroids, surgery) can be invasive and may cause side-effects that complicate a survivor's overall health (Triebel et al., 2012). Other TBI treatment strategies include psychotherapeutic treatments and cognitive rehabilitation, which could facilitate neuroplasticity. However, the reflexive relationship between affective and cognitive symptoms complicates standard-bearing traditional psychotherapy and cognitive rehabilitation techniques. For example, modifying emotional responses may affect the motivation that influences fundamental cognitive abilities (Kay et al., 1992) and, conversely, altering fundamental cognitive abilities may influence emotional processing by influencing the perception of or modulating the salience of environmental stimuli (Ignacio, 2016).

Cognitive deficiencies impede independence, necessary lifestyle changes, and may promote a loss of sense of self through changes resulting from the TBI, which contribute to feelings of depression, anxiety, or post-traumatic stress symptoms (Kaup et al., 2019). For example, a lack of improvement in psychiatric concerns, but improvements in cognitive measures would suggest that cognitive rehabilitation interventions may not generalize to domains other than cognition, and cognitive symptoms may be linked to associated stressors instead of the injury itself (Julien et al., 2017). Thus, a best practice may be to target affective and cognitive domains jointly in vocational rehabilitation for community-dwelling survivors. Although the Ontario Neurotrauma Foundation (2018) has published clinical practice guidelines, there is minimal consensus of how to approach standardized rehabilitation following TBI of any severity, specifically within the U.S. Further research is needed to address these treatment concerns and accurately inform the scientific community to ultimately guide public policy and reform.



*Dylan G. Serpas*

### Policy Implications and Future Directions

There is variability in U.S. legislative policies, specifically for standardized clinical practice guidelines, which is a major factor in TBI treatment disparities. With a few exceptions, most of the U.S. lacks standardized treatment practices for TBI assessment and treatment. Developing standards of care for TBI will assist to reduce treatment disparities and poor functional outcomes for community-dwelling survivors. At medical discharge, survivors may not have any integrative support promoting mismanaged symptoms (Lamontagne et al., 2018). To rectify this, a referral-based system that survivors can interact with online, in-person, or over the phone could adequately address rehabilitation needs based on demographics and injury characteristics (e.g., severity). For instance, there is a network of seven sites across the state of California that is grant funded by the Department of Rehabilitation to serve survivors of TBI and their families; however, each site receives a fixed amount to serve a large catchment area, which restricts provision of services and limits the impact of community-integration practices.

Supporting integrated state-wide registries to improve high-quality data on real-time incidence may encourage a standardized pipeline of the recovery process with appropriate rehabilitation referrals. This would adequately fund service-providers to facilitate successful community reintegration. Several states have attempted to accomplish this with varying degrees of success. For example, Maryland has a law that mandates medical centers to provide incidence data on TBI but does not provide funding or enforcement to do so, whereas Alabama maintains an integrated data registry with limited funding. California's TBI Advisory Board also does not have a dedicated data registry, but for a different reason than Maryland, and is loosely connected to their state's designated trauma registry; whereas, Virginia's TBI board is integrated. Moreover, rehabilitative services (e.g., adult day care, cognitive rehabilitation, home accessibility modifications, respite, supported employment) are provided through a Medicaid sponsored Home and Community-Based Services (HCBS) waiver. Several states with high a concentration (>30%) of rural communities currently do not provide HCBS waivers to their citizens (e.g., South Dakota, Oklahoma, Arkansas, North Carolina; NASHIA, 2014; U.S. Census Bureau, 2016).

Variability in operational definitions, physical versus neurocognitive symptoms, and varying ability to collect high-quality empirical data on incidence has



restricted the ability to derive meaningful findings and provide directed care to these survivors of trauma, particularly those who are experiencing post-concussive symptoms along with mental health comorbidities. When evaluating potential treatments for inclusion in treatment standards, particular attention needs to be placed on co-occurring problems associated with TBI (e.g., homelessness). As much as 53% of the homeless population is estimated to have a history of TBI, and a subset of approximately 70% of these individuals is estimated to have had their TBI prior to the onset of homelessness (Stubbs et al., 2009). Many of the previously described symptoms of head injury are the leading risk factors for homelessness, both of which have been empirically associated with adverse health outcomes such as schizophrenia, drug misuse, suicidal ideation, and a higher incidence of psychiatric diagnoses (Stubbs et al., 2019). Collectively, these problems have contributed to treatment disparities salient to TBI that, at present, have promoted mismanaged symptoms, thus leading to poorer prognoses for comprehensive recovery among community-dwelling survivors.

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assess neurocognitive status, understand factors relevant to resilience, and manage post-concussive symptoms to assist survivors in successfully reintegrating into their communities.

*Dylan G. Serpas is a first-year Clinical Psychology M.S. student at California State University, Fullerton. Mr. Serpas' research interests center on the mechanisms*

*by which health disparities arise in marginalized communities and the modifiable risk factors that may reduce the burden of their disproportionate incidence. He intends to continue advancing the scientific inquiry of psychology through empirical research and clinically-relevant explorations specifically in the area of health disparities within a health research-oriented Clinical Psychology Ph.D. program, following the conclusion of his current degree.*

## Who's Who: Rachel Wamser-Nanney, Ph.D.

### 1) What is your current occupation?

I am an Assistant Professor in Psychological Sciences at the University of Missouri- St. Louis.

### 2) Where were you educated?

I completed my doctoral degree at the University of Missouri- St. Louis, including my predoctoral internship at Tulane University Health Sciences Center where I was fortunate enough to be part of the Tulane Infant Team which works with maltreating caregivers. I then completed my postdoctoral fellowship at the University of Michigan.

### 3) Why did you choose this field?

I became interested in traumatic stress after completing my first undergraduate research assistantship, which was focused on childhood trauma treatment at the Center for Trauma Recovery. As I entered treatment outcome data, I was struck by the efficacy of trauma-focused interventions for children. I really admired the dedicated and talented clinicians working on the project and aspired to be like them to also help trauma-exposed children. In spite of the horrific traumatic experiences these children had survived; there were so many stories of incredible resiliency. Every time I think back on it, I still find this experience really inspiring and motivating.

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

I find most aspects of my job incredibly rewarding- it is hard to pick one! I think it is such an honor to be a professor and teach future generations of undergraduate and graduate students. I really enjoy working with my students and enjoy their energy and excitement (it is contagious!). I am also humbled by and feel very privileged to hear people's life stories and oftentimes their darkest moments, and to try to help

them make sense of and contextualize their traumatic experiences.

### 5) What is most frustrating about your work?

Many of my clinical and research interests are in the areas of complex trauma, intergenerational trauma, and gun violence and I really enjoy working with under-served populations and maltreating caregivers.

However, I find the lack of access to basic resources for these clients very disheartening. Over and over again, clients present to trauma-focused treatment (which is often heroic in itself for many reasons!) but do not have the luxury of focusing on mitigating their trauma symptoms due to trying to get their basic needs met. I feel strongly that, for many, their quality of life (and trauma symptoms) would be much improved if they had adequate housing and employment opportunities. I also find the very reactionary nature of our programming and funding sources frustrating- I wish that we would really focus on prevention, trauma-focused screenings, etc. and be more proactive at preventing trauma exposure and symptoms.



*Rachel Wamser-Nanney*

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

I am grateful to be the mother of two girls (Charlotte age 2, Emma 3 months) and wife to my dear husband John. My family time keeps me balanced and passionate about my work. I also enjoy running, boxing, reading, art, and cooking. Running and boxing in particular have been instrumental in managing secondary traumatic stress.

### 7) What are your future plans?

My future plans include improving assessment and treatments for trauma-exposed families as well as further developing prevention interventions regarding gun violence. I also hope to do more child maltreatment prevention work in the future and work to better support caregivers of trauma-exposed children.



# Misplaced

## Latinos are also part of the human race

Rita Rivera

“Worst place,” they say  
as there is not enough bread.  
“It’s hell,” they yell  
as daily, there are hundreds dead.

Violence and crime  
have lasted a lifetime.  
Corruption and destruction  
make our nations suffer.

Children born with a gun  
or children born because of a gun.  
Children transformed to mothers and fathers  
or children sold by their mothers and fathers.

What is this place?  
And what is this race?  
These countries, in this world, have been misplaced.  
Can’t you see the peace that drowns other states?  
Can’t you see they do not share our horrible traits?  
There is no blood spilled,  
for only in *Latinoamérica* people are killed.  
There is no robbery and no lies,  
for water, in the perfect land, never dries.  
There is no crime,  
for there is never enough time;  
they must work and work to earn each dime.

What is this place?  
And what is this race?  
These nations have been misplaced.  
To this world, we do not belong  
for we are the only ones that do wrong.  
As long as we stay strong,  
we will continue to play along.  
What is this place?  
And what is this race?  
Latinos, in this world, have been misplaced.  
We are not better or worse:  
Latinos are also part of the human race.

**Rita Michelle Rivera** is currently pursuing her doctoral degree in Clinical Psychology in Miami, Florida. She is originally from San Pedro Sula, Honduras. Rita has a Bachelor of Science in Psychology and a Bachelor of Arts in English from Palm Beach Atlantic University. Growing up in what is considered one of the most violent cities in the world, Rita became interested in psychology as she observed the impact that violence and abuse could have on individuals’ mental health. She aspires to become a professional clinician who helps trauma victims in their journey to recovery.



Rita Rivera

# Greatest Secret of Gratitude

*Dr. Ani Kalayjian*

“Life without thankfulness is devoid of love and passion. Hope without thankfulness is lacking in fine perception. Faith without thankfulness lacks strength and fortitude. Every virtue divorced from thankfulness is maimed and limps along the spiritual road.”

~ **John Henry Jowett**

Gratitude is the greatest secret ever!  
 Gratitude is indeed like a gear shift, that  
 Can move our mental mechanism from obsession to peacefulness,  
 From stuckness to freedom, from fear to courage,  
 From anxiety to relaxation and bliss,  
 From worry to peaceful surrender!

The great secret of gratitude is that it's  
 Not dependent on external circumstances, such  
 As the rain, the snow, your neighbor, nor your partner.  
 It's like a setting or a channel that we can switch to  
 At any moment, no matter what's going on around us.  
 It helps us connect to our basic right to be here, and to be in joy!

The great secret of gratitude is that  
 It increases our happiness by 25%,  
 It helps us cope more effectively with everyday stress,  
 It will increase resilience in the face of trauma induced stress, and  
 Help us recover more quickly from illness and  
 Improve our physical health (R. Emmons).

Instead of feeling grateful **to** someone, we feel grateful **for** them;  
 We feel grateful for God or Spirit working through them,  
 We begin to feel grateful for everyone and everything in our lives,  
 This feeling uplifts us and energizes us internally, like oxygen does to our cells,  
 We then help uplift others, and embrace others without judgment,  
 Knowing that we are, in fact, in this world together in harmony.

Gratitude, in the form of counting our blessings  
 Has been shown to be related to subjective well-being,  
 And gratitude induction is related to enhanced well-being,  
 Which remarkably decreases our negative affect.  
 When we start being grateful for small things,  
 Life begins to make sense, we discover a positive meaning,  
 And we begin feeling fortunate, full of love, and purposeful.

There are two ways to live your life. One is as though nothing is a miracle.  
 The other is as though everything is a miracle.”

~**Albert Einstein**



# The Body Holds Trauma, Full Stop

Leticia M. Berg

How to put into words the rage that bubbles up inside when I think...of all that I suffered but did not know how to resist...of what I know now that the preschooler, the child, the teenager did not yet know?...Of all the times I smiled and stayed calm -- for the sake of everyone else's comfort -- when inside I felt torn to shreds and like I wanted to scream bloody murder...of how the body holds trauma, sadness, depression, sorrow and pain and wears it like an invisible armor, like an albatross around one's neck.

**People say,** *"Why does this matter so many years later?"*

Because a life, or more accurately, a soul was lost. Because part of my essence, part of my spirit, died when I was used as a piece of irrelevant meat simply to serve someone else's twisted satisfaction.

**People say,** *"Just move on and get on with your life!"*

That's exactly what I did. But the broken version of me that moved on was not properly equipped or prepared for the playing field of life.

**People say,** *"That person is a good person and they would never do such a thing that you are accusing them of!"*

But they did. And they, and others like them, keep getting away with it because people keep believing their lies.

**People say,** *"you're just weak willed...we've all had challenges in life. Grow a spine and just be strong!"*

Ha!!! Sex abuse and brutality survivors are some of the strongest people I know. Somehow, we find the courage and the will to get up and live every day when we feel so worthless, ashamed, used, unloved and beaten down. Not to mention trying to keep a lid on our repressed rage, resentment and hatred for our unpunished and unrepentant attackers.

Here's what made me angry this morning, (one of the 17 million times in my life that I have to deal with anger suddenly bubbling up, well, **BECAUSE**):

As I watched my 14-year old daughter happily ride her bike to school with an innocent smile on her lovely,

optimistic, trusting face...I thought about the fact that at her age, I had already been seriously sexually assaulted **THREE** times. Twice by members of my own family.

**Yet, I'm still here.**

**DON'T YOU EVER TELL ME I'M NOT STRONG.**

**BUT,** guess what? 40 years later, there's a big part of me that still feels broken, incomplete and somewhat alone. **THE BODY HOLDS TRAUMA.** Full Stop.



Leticia M. Berg

There was a time when I looked to my mother, or my friends or my husband to "heal" me. Moreover, even though I was looking for healing, I didn't know I was looking for healing. For the longest time I didn't see myself as a victim, I saw myself as tough, realistic and capable of creating any reality I wanted. After all, I had survived the massacre of my innocence. I was "FINE." Everything was always "FINE."

I traveled, went to college, held a bunch of different jobs, collected friendships, loved and lost in relationships...but there was always

something missing. Somewhere deep inside I knew something was wrong, but I couldn't put my finger on exactly what it was. Of course, that little voice in my head kept trying to tell me that it was **ME** that was wrong. Just me. And I heard that voice in my head, constantly, **from the very moment that my 5-year old body was invaded by a grown man's penis.** In order to drown that damaging voice out, the scared, overwhelmed, confused little girl put on the tough, capable, realistic women's armor and tried to hide, or at least, step around, the truth. But in that armor, clumsily and hastily donned far too soon, I kept bumping into walls of fury, secrets, shame, confusion, blame and self-hatred. Walls that blocked me from seeing who I truly was and what I could truly be...if I were whole. But I wasn't whole...something was missing. And that little, assaulted voice inside never failed to remind me of that.

In spite of **ALL** of that, though, **I'm still here.** Broken and battered but still gasping for air and trying to claw my way out of the pain. **DON'T EVER TELL ME I'M NOT A SURVIVOR.**

I'm fighting every day to find my sense of wholeness. And guess what? I'm **WINNING.** Because of ongoing therapy, survivor support groups, psychoeducation and a loving circle of people that I know I can count on

when I'm feeling low, I learned how to turn what I've been through around to create purpose and meaning, not only to restore me to myself but also as a tool for helping others to find their own journey toward healing and wholeness. To those who may be hearing "whispers" or who find themselves being a keeper of family secrets: PLEASE listen to the children around you. Talk to them about boundaries and respect them if they don't want to have a hug today. Most importantly, let them know that you are there for them and, Believe Them if they tell you or in any way indicate that they feel uncomfortable around certain people.

Lastly, I want to say to those who are still in the midst of pain and struggle:

I'VE HELD ON TO MY HURT, SHAME AND ANGER FOR A REASON. IT PROTECTED ME WHEN I FELT LOST AND ALONE .... BUT IT WAS OKAY TO BEGIN

THE PROCESS OF LETTING THOSE FEELINGS GO AND TRANSFORMING THEM INTO POWER. I WON'T EVER LET ANYONE TELL ME THAT I AM BROKEN or NOT STRONG. I AM A SURVIVOR AND MY PAIN IS MY SUPERPOWER. I CHOOSE TO USE IT FOR GOOD.

*Leticia Berg is a doctoral student at Fielding Graduate University. She will graduate in January 2023 with a PhD in Media Psychology. She has a Master's Degree in clinical psychology and is currently working in private practice as a psychotherapist at Arbor Wellness in Ann Arbor, Michigan. Leticia's work experiences include providing therapy for the LGBTQ population in a community mental health center and assisting with research studies on Autism Spectrum Disorders and ER Head Trauma patients. Her areas of clinical interest are mainly focused on trauma, sexual abuse, domestic violence and social justice.*

## FIND ME

### Katie Close

Who was I when I started this  
Who did I think I would become  
Who did I believe I could ever save  
Who was there to place my trust upon

What got me here standing in the cold  
What brought the darkness into my soul  
What if I can't walk down this road  
What memories will lead me home

Find me here  
Find me now  
Find me somehow

Where is the honor in feeling afraid  
Where can I go to escape so much shame  
Where did the bold determination go  
Where is the hope I don't know

When I'm asleep I dream of death  
When I'm awake I can't catch my breath  
When I get lost I'm somewhere in between  
When will it be that I come clean

Find me here  
Find me now  
Find me somehow

Why can't I overcome this rage  
Why does my mind fight to engage  
Why is the noise so deafening  
Why is everything so threatening

How can I live without the brotherhood  
How will I ever be understood  
How long will it take for me to mourn  
How many times will I be reborn

Find me here  
Find me now  
Find me somehow



Katie Close

*Katie Close served in law enforcement in Northern California for 15 years and held collateral assignments of K-9 Officer, Defensive Tactics Instructor, and Peer Support Coordinator. During that time, she also volunteered as a law enforcement chaplain for surrounding agencies. She was medically retired for job-related PTSD in 2018. She now volunteers for the First Responder Support Network as a peer at West Coast Post-trauma Retreat.*



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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.

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

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### Join Division 56 Today!

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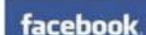
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DIVISION 56

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

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<u>Issue</u>	<u>Submission Deadline</u>	<u>Publication Date</u>
Summer	June 8	Late July
Fall	September 8	Late October
Spring	March 8	Late April

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