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DIVISION 56

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

NEWSLETTER

A View Inside

Presidential Voice

Welcome to 2008!

Robert Geffner, PhD, ABPP, ABPN
Institute on Violence, Abuse and Trauma
Alliant International University
San Diego, CA

As we move into our second year as a full Division of APA, it is my pleasure to thank the outgoing Board members who have done an excellent job helping us move forward: Laura Barbanel (Member-at-Large), Melba Vasquez (Treasurer), and Emily Snow Jacobs (Student Representative). The Board for 2008 is outstanding, and I appreciate the opportunity to work with all of them for our second full year. Judie Alpert now moves to our first Past President, and we welcome Steve Gold as President-Elect, Beth Rom-Rymer as Treasurer, Lisa Butler as Member-at-Large, Charles Figley as Council Representative, and Patrick Meade as Student Representative. Those who are leaving the board are doing so in title only since once a board member, always an honorary one for the division!!!

Robert Geffner, PhD, ABPP, ABPN

This year many important milestones are on the horizon. Two occur in February: the APA vote to make us a permanent Division and the first APA *Summit on Violence and Abuse in Relationships: Connecting Agendas and Forging New Directions.* We are looking forward to Division 56 becoming an officially permanent part of APA!! With respect to the Summit, this is your last chance to register on the website (see flyer on Page 4). Division 56 is a lead division for this, along with Division 35 (Society for the Psychology of Women), which is part of Alan Kazdin's APA Presidential Initiatives. This event will have a major impact on promoting ways for APA and other collaborating organizations to have more influence on reducing and eliminating such an important social and public health problem. There are now 17 APA Divisions collaborating on this Summit, along with more than 10 agencies, organizations and foundations. Each attendee will have the opportunity to interact with others who have multidisciplinary expertise in their fields of interest, and take part in focus discussion groups.

The outcome of this Summit will be used to stimulate actions and for

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David Letterman's Top Ten

Judie Alpert
New York University

My term as President of Division 56 ended on December 31, 2007. As I look back on my time in office, a list of some of the highlights during my presidency is in order. Let's call this "David Letterman's Top Ten." Unlike Letterman, however, I list these in no particular order. Also, I am unable to provide the music appropriate for a top ten delineation. Please, as you read, create your own internal trumpet blast.

Number One: Formation of the Division.

Our goal was to start a division and, thus, to put trauma on the APA map. The division is very much alive and well. I'd like to think that some of the activity on trauma outside of the division is in response to all the energy generated by our division. For example, the APA Board of Convention Affairs voted to add "trauma" as a separate category listing in the convention programming list of topics. It is surprising that this was not a separate category before, but it is wonderful that it is now. As another example, Alan Kazdin, President-Elect of APA, is convening a task force to identify psychologists' current understanding of and contributions to the amelioration of PTSD and trauma, to summarize the current state of scientific knowledge in the field of psychology, and to make recommendations appropriate to different populations for dissemination to the public and to policy makers. For sure, trauma is on the APA map!

Judie Alpert, PhD

Number Two: Membership High and Growing

We have only been in existence for one full year. Nevertheless we have over 1,200 members. Sandra Mattar has done an outstanding job as membership chair. She is now beginning to organize membership drives on a regional basis.

Number Three: Noteworthy Newsletter

One comment I hear consistently concerns the newsletter. All agree that Topher Collier (and his "staff") has done a superb job in creating a substantial (in length and in content) newsletter!

Number Four: Welcoming Web

Laura Brown is our web master. Check it out at **www.apatraumadivision.org**. It is wonderful, and Laura updates our site regularly.

Number Five: Advocacy Activity

Advocacy activity was undertaken by Division 56 committees as well as by other members in the division. For example, the Science Committee, under the leadership of Jennifer Freyd, organized letter-writing campaigns in response to the absence of discussion of trauma-related factors in mental health in the Strategic Plan draft issued by the National Institute of Mental Health. Her committee, on behalf of our Division, called for the inclusion of trauma as a variable to be prioritized by NIMH for research and funding. In addition, Jennifer led the Division 56 Science Committee to write a scholarly response to an article published in the *Boston Globe* which contained misinformation about trauma and memory. Others involved in writing this letter, which was sent to the *Globe* just a few days after the story was printed, included Terry Keane, Cathy Classen, Mary Koss, and David Gleaves. Bob Geffner, Laura Brown, and I also contributed, and we were active in communicating with APA press office staff about their role in the story.

Advocacy activity will continue. Chris Courtois, as Chair of the Practice Committee, is involved in a number of advocacy-related projects. Also, we have joined with ten other divisions and have become part of the Divisions for Social Justice.

Number Six: Three Task Forces

There are three task forces which are presently hard at work. Nnamdi Pole is chairing the Task Force on *Coercive Interrogations and Torture*. He, along with task force members, is planning to present some material to our division Executive Committee (EC) board at our February meeting. Jaine Darwin is chairing a Division 56 Task force on *Trauma in the Military and their Families*. Jaine and her task force members will be considering such issues as the training of those diagnosing and intervening with the military; treatment of PTSD of military folk; diagnosis of PTSD by military folk; and issues raised by military families. Terry Keane is chairing the Task Force which will provide input on the developing *DSM-V*. Terry, along with his task force members, will be working to get other bodies within our APA to take a stance as well.

Number Seven: An APA Convention Packed with Firsts

Steve Gold and Joan Cook did a phenomenal job organizing the programming for our Division's first presentations at the annual convention. By means of creative networking, they were able to get the Division more program hours and to reduce the cost of our convention suite. So many "number ones" occurred at this 2007 APA convention which took place in San Francisco. In addition to superb programming, we had our first major Board meeting, our first Presidential address, our first hospitality suite, our first awards (thanks to Awards Chair Laura Barbanel with on-site presentations by Terry Keane), and our first fundraising event (thanks to Kathy Kendall-Tackett and Emily Jacobs), which was a silent auction of books donated by division members. To defray some of the costs for our hospitality suite, Investment Committee Chair (and Treasurer) Melba Vasquez and her committee raised $1,775 in contributions from division members.

Number Eight: Special Interest Groups

There is a lot of excitement about our Special Interest Groups. At least three are already up and running. They are:

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AMERICAN PSYCHOLOGICAL ASSOCIATION

REGISTER NOW

Summit on Violence and Abuse in Relationships: Connecting Agendas and Forging New Directions

February 28-29, 2008 Bethesda, Maryland

Alan Kazdin, PhD, President of APA, has selected this summit as part of his presidential initiative. Topics include Intimate Partner Violence, Child Maltreatment, Children Exposed to Violence, Sexual Violence, Substance Abuse, Teen Dating Violence, At Risk Groups, Special Populations, and related themes. The focus will be on What We Know, What We Need to Know, and Where Do We Need to Go with respect to Research, Intervention, and Prevention. Issues of gender, culture, and intersecting identities are emphasized. The program will consist of 6 plenary speakers, 8 tracks with follow up break-out groups, and a Town Hall at the end. More than 25 keynote speakers and special guests will do presentations and lead discussions.

Conference Schedule
February 28: Opening Plenary, Poster Session, Networking Reception
February 29: Summit Programming

Coordinators
Jackie White, PhD, President, Div 35
Bob Geffner, PhD, President, Div 56

Plenary Presenters
Mary Koss, PhD, Jacki McKinney, Rodney Hammond, PhD, Ann Coker, PhD, Wanda Jones, DPH, and David Finkelhor, PhD

Host Hotel
Hyatt Regency Bethesda (888) 591-1234: *Reservations link at* www.reisman-white.com (special conference rate code- **G-TPSY)** $189 s/d

In addition to the two lead divisions, Division 35, Society for the Psychology of Women and Division 56, Trauma Psychology, preliminary co-sponsors of this summit are: Robert Wood Johnson Foundation, Centers for Disease Control (CDC), International Society for Research on Aggression, and the University of Kentucky's Center for Research on Violence Against Women. The following APA divisions and organizations serve as collaborators:

- **8** – Society for Personality and Social Psychology
- **9**- Society for the Psychological Study of Social Issues
- **17**- Society of Counseling Psychology
- **22**- Rehabilitation Psychology
- **27**- Society for Community Research, and Action: Community Psychology
- **28**- Psychopharmacology and Substance Abuse
- **37**- Society for Child and Family Policy and Practice
- **39**- Psychoanalysis
- **41**- American Psychology-Law Society
- **43**- Family Psychology
- **44**- Society for Psychological Study of Lesbian, Gay, and Bisexual Issues
- **45**- Society for the Psychological Study of Ethnic Minority Issues
- **48**- Society for the Study of Peace, Conflict, and Violence
- **50**- Addictions
- **51**- Society for the Psychological Study of Men and Masculinity
- Interdivisional Task Force on Child Maltreatment Prevention
- National Center on Domestic Violence, Trauma and Mental Health
- International Society for Study of Trauma and Dissociation
- Leadership Council on Child Abuse and Interpersonal Violence
- International Society for Traumatic Stress Studies
- National Child Traumatic Stress Network

The Institute on Violence, Abuse and Trauma at Alliant International University is a co-sponsor of this Summit, and is responsible for the Continuing Education program. Up to 8.5 hours of CE credit are available for psychologists, social workers, marriage and family therapists, nurses, attorneys, substance abuse and other counselors.

For information, the program, and to register for this summit, go to www.APAViolenceSummit.org or call (512) 845-9059

RW Reisman-White
Today's Planners for Tomorrow's Success

Give an Hour: An Incredible Non-Profit Looking to Build a National Network

Joan M. Cook, PhD
Yale University School of Medicine
Joan.Cook@yale.edu

Joan M. Cook, PhD

Dear Colleagues,

I recently learned about this wonderful nonprofit organization that is currently dedicated to helping soldiers and their families affected by the ongoing conflicts in Iraq and Afghanistan. I ask you to please read the information on this organization below and to consider passing it forward to other trauma clinicians.

Thank you for your consideration,
Joan

Large numbers of veterans are returning home from Iraq and Afghanistan with a wide range of psychological difficulties, severe physical injuries and traumatic brain injuries. There are estimates that at least 12% of the returning soldiers will come back with a serious mental disorder and as many as a third are returning with significant psychiatric symptoms.

Family members are also severely affected by a soldier's experience of trauma. Indeed, "secondary trauma" is a significant mental health consequence of war. Children who grow up in families where Post Traumatic Stress Disorder is not treated often become severely impaired themselves.

Although the U.S. military is clearly trying to stay in front of this issue, making an unprecedented attempt to encourage personnel to seek treatment, limited access, resources and stigma may prevent many from receiving needed mental health care.

There are over 400,000 mental health professionals in the U.S. Being such a professional is a privilege and comes with it an obligation. Now is such a critical time to honor such an obligation and take an opportunity to help our country and its wounded. Give an Hour is a nonprofit organization whose mission is to develop a national network of mental health volunteers capable of responding to both acute and chronic conditions that arise in society. Their current effort is to establish a national network of mental health professionals to reach out to the U.S. troops and families affected by the current military conflicts in Afghanistan and Iraq.

Thus far, nearly 1000 mental health professionals have registered to participate in this critical effort. These professionals have agreed to give an hour of their time each week to provide free mental health services to military personnel and their families. Professionals are being asked to provide the type of services they currently provide in their offices. While no additional training is required, Give an Hour is offering a variety of training opportunities to those individuals who might be interested. In addition, these professionals have the opportunity to interact with each other, to share information about their experience and to seek feedback and additional resources.

Mental health providers are asked to participate in the Give an Hour network for one year in order to provide continuity of care for these deserving families. Over the past few months, Give an Hour has started to match members of the military community in need with members of their network. Indeed, they are now hearing from military personnel and their families on a regular basis. Many of these men and women share their stories and express their gratitude. They are so thankful that members of the mental health community have stepped up to join this effort.

Give an Hour has developed important relationships with many Veterans' Service Organizations including the American Legion Auxiliary, TAPS (Tragedy Assistance Program for Survivors), the National Gulf War Resource Center and Vets 4 Vets. As a result of these relationships, the mental health professionals have opportunities to work with volunteers from these organizations to co-lead support groups and participate in community events.

Give an Hour is seeking a broad national network of mental health professionals to join in this critical effort. If you are currently licensed, please visit their Web site **www.giveanhour.org** to sign up for the national network and to learn more about their organization.

Welcome to Division 56!

The Division's electronic newsletter, Trauma Psychology, is published three times a year in Spring/Summer, Fall, and Winter and is posted in the Division's website http://www.apatraumadivision.org

If you would like to join the Division's listserv, please send an email to Preetika Mukherjee (pp457@nyu.edu).

We appreciate your interest in our Division and hope you will encourage your colleagues to join. For additional information about Division 56 membership, please contact Sandra Mattar, PsyD, Division 56 Membership Chair, via e-mail (smattar@jfku.edu) or telephone (925-969-3405).

Trauma-Informed Approaches to Systems of Care

Roger D. Fallot, PhD, and
Maxine Harris, PhD
Community Connections
Washington, DC

In considering ways to respond helpfully to those affected by traumatic experiences, we have made a basic distinction between "trauma-specific" and "trauma-informed" services (Harris and Fallot, 2001). *Trauma-specific* services are those whose primary task is to address the impact of trauma and to facilitate trauma recovery. These services include individual and group therapies designed to ameliorate posttraumatic stress disorder symptoms, such as exposure therapy and cognitive reprocessing therapy, as well as those interventions whose goal is to foster trauma recovery more broadly. By contrast, *trauma-informed* systems and services are those that have thoroughly incorporated an understanding of trauma, including its consequences and the conditions that enhance healing, in *all* aspects of service delivery. *Any* human service program, regardless of its primary task, can become trauma-informed by making specific administrative and service-level modifications in practices, activities, and settings in order to be responsive to the needs and strengths of people with lived experience of trauma.

Roger D. Fallot, PhD

Becoming trauma-informed, in this sense, entails a shift in the culture or "paradigm" in human services. It involves changing the ways we *think*—about trauma itself, about the survivor, about services, and about the services' relationship—as a prelude to changing the ways we *act* in structuring and offering services. In such settings, trauma moves from the periphery to the center of the staff's understanding. Rather than asking, "What is your problem?" trauma-informed providers may ask, implicitly or explicitly, "What has happened to you? And how have you tried to deal with it?" Rather than adopting a stance of "Here is what I can do to help you," a trauma-informed approach asks, "How can you and I work together to meet your goals for healing and recovery?" In every aspect of the program's functioning, there is enhanced awareness of the ways in which trauma may have affected people coming for services. There is a corresponding shift in attitude, services, and the physical setting in order to welcome, engage, and sustain helpful relationships with consumer-survivors.

From a large number of conversations discussing trauma-informed changes with program administrators, staff, and consumer-survivors, we have distilled five core principles to guide agency self-assessment and planning: *safety, trustworthiness, choice, collaboration, and empowerment*. The broad assessment questions are straightforward. To what extent do current service delivery policies, practices, and settings: (1) ensure the physical and emotional safety of consumers? Of staff members? (*Safety*); (2) provide clear information about what the consumer may expect? Ensure consistency in practice? Maintain boundaries, especially interpersonal boundaries, appropriate for the program? (*Trustworthiness*); (3) prioritize consumer experiences of choice and control? (*Choice*); (4) maximize collaboration and the sharing of power with consumers? (*Collaboration*); and (5) emphasize consumer empowerment? Recognize consumer strengths? Build skills? (*Empowerment*).

Our approach to facilitating trauma-informed modifications draws on these principles as they are enacted at both the services and administrative levels. First, agencies review the extent to which their day-to-day service procedures and settings are welcoming and hospitable for trauma survivors and the extent to which they minimize the possibility of retraumatization. Program administrators, staff, and consumers consider each step of a prospective service recipient's experience with the program, from initial to final meeting. They ask a variety of questions relevant for their program. What is the usual first point of contact? By telephone or in person? Who is likely to greet the individual? With what information? How engaging and nonthreatening are these initial contacts likely to be, especially for people with histories of abuse and related interpersonal concerns? Are the physical settings responsive to the needs of trauma survivors? Are there private areas for confidential conversations? Questions like these address the full range of service relationships over the course of a person's involvement with the program.

Maxine Harris, PhD

Agencies have made a very wide variety of changes in response to this exercise. For example, one program found that waiting room "love seats" felt very uncomfortable for abuse survivors, that such seats encouraged unwanted physical contact and left little personal space. The agency enhanced a sense of *safety* by removing these seats and replacing them with single chairs. Another program focused on strengthening its *trustworthiness* by publishing more clearly in advance the schedule for its many group interventions. Group leaders then adhered to that schedule as closely as possible and informed group members well in advance of any anticipated changes. In maximizing experiences of *choice* and *control*, an agency adopted a "person-centered recovery planning" approach that emphasizes consumers' priorities in all aspects of the services they receive, including a formal "statement of consumer preference" for responding to crises. A counselor decided to change her usual intake interview setting and practice so that the prospective consumer had the option to sit beside her and review necessary paperwork with her. She reported that this arrangement fostered a more *collaborative* relationship than her former, traditional question-and-answer approach. A community support specialist offered an anxious consumer she had accompanied to a doctor's office the opportunity to practice relaxation and visualization, key self-soothing skills that would facilitate *empowerment* in

many situations. One program focused on its signs and visual environment. They added encouraging and affirming posters while removing or rewriting unnecessarily "commanding"—and sometimes condescending—informational notices.

In addition to this review of basic activities and settings, program assessment and planning involves a detailed look at two other services-level domains: formal, usually written, policies and trauma screening/assessment/referral. Agencies, for example, have addressed both written policies requiring informed consent and the processes (timing, pacing, etc.) by which informed consent is discussed. In this way, time and effort are invested in ensuring that the "routine" obtaining of consent is both meaningful and valid. Similarly, programs have re-examined their policies about how to de-escalate interpersonal conflicts in ways that maximize safety for consumers and staff; they have also instituted careful reviews to be certain that the policies are implemented as written. Universal trauma screening is normative in trauma-informed agencies and is followed, as appropriate, by more in-depth assessment of trauma and its impact. Deciding on the content of this screening and assessment process has afforded opportunities for many agencies to consider the kinds of trauma prospective consumers are most likely to have experienced. Programs then frequently highlight the importance of this assessment by monitoring the extent to which the information is incorporated in service planning and in referrals to needed trauma-specific services.

A similar review of three domains at the administrative level follows: administrative support; trauma training and education; and human resources practices. Because becoming trauma-informed involves significant shifts in both the "culture" and the "system" of a program, administrative support for, and active participation in, such initiatives is a necessity. Engaging all stakeholders or constituencies is also essential, including, perhaps most importantly, those people who are receiving, or have formerly received, services at the agency. Many programs that have developed a consumer advisory group as part of a trauma-informed initiative have found that consumer participation expanded naturally into major roles in planning, implementing, and evaluating services. No other single shift has had such major impact as this enhanced role of consumers. Those programs most successful in developing significant and lasting trauma-informed approaches have engaged frequently underrepresented groups—administrators, support staff, and consumers, especially—in all aspects of the change process.

Education about trauma and its impact has proven, not surprisingly, to be central in virtually all change efforts. All staff, including support and administrative staff, can benefit from an understanding of trauma-related concerns and the factors that facilitate recovery. For example, many programs have decided to prioritize education and consultation for its reception staff in how to handle calls and face-to-face visits with distressed or angry people. When staff learn how to respond helpfully to those who are distraught, they not only avoid escalating conflicts but also contribute to their own safety and sense of competence. There is an additional factor in favor of such education: because trauma-informed changes address program-wide issues, there is an emphasis on *staff members'* experiences of safety, trustworthiness, choice, collaboration, and empowerment alongside that of consumers. Attention to staff support and care has become increasingly important in a time of "do more with less" resource allocation.

Addressing trauma in staff hiring, orientation, retention, and promotion is a final avenue to systemic change. Programs have developed trauma-centered vignettes for use in interviewing prospective staff to gauge both knowledge of, and responsiveness to, trauma experiences. They have incorporated basic information about trauma in orientation, emphasizing trauma's importance in shaping their approach to services. They have put in place incentives for staff who pursue and use additional education in trauma-related areas.

Quantitative studies of the effectiveness of trauma-informed approaches to service delivery have recently been published (Morrissey et al., 2005). Qualitative findings from our consultations have been promising. In programs that have implemented this process, each of the major constituency groups—administrators, direct service staff, and consumers—have reported positive responses to trauma-informed changes in the system of care. The most common theme, one that is echoed across various groups, is an experience of greater collaboration and trust. As one consumer stated, whereas she had previously felt it necessary to leave part of herself outside the agency door, the trauma-informed initiative made it possible for her to "bring her whole self" to the program. A trauma-informed culture ideally expresses just this kind of openness to, and engagement with, the full experiences of trauma survivors.

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Spring/Summer 2008 Issue

The *Trauma Psychology Newsletter* is accepting articles for the Spring/Summer 2008 issue. The deadline for submissions is **April 15, 2008**. Suggested article length is 1,500 words, submitted in MS Word or Wordperfect formats. Submit articles for consideration to Topher Collier, Newsletter Editor, at DrTopherCollier@aol.com.

Violence against Women and the Perinatal Period: The Impact of Lifetime Violence and Abuse on Pregnancy and Postpartum

Kathleen Kendall-Tackett, PhD, IBCLC

Violence against women (VAW) is an unfortunate fact of life for millions of women around the world. And mothers are not immune. A recent study of 332 postpartum women in Toronto found that 14% reported a history of child sexual abuse, 7% reported child physical abuse, 13% reported adult sexual abuse, 7% reported adult physical abuse, and 30% reported adult emotional abuse (Ansara et al., 2005). Abusive experiences, both past and present, can influence women throughout the childbearing cycle. Below is a summary of what we know so far on how VAW influences women during pregnancy and postpartum.

Pregnancy

VAW influences women's health during pregnancy. The effect of intimate partner violence (IPV) during pregnancy has been well-documented. What is less well-known is that past violence could also impact the health of mother and baby during pregnancy. The samples in the majority of these studies are survivors of childhood sexual abuse.

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Several recent studies have found that high-risk sexual activity is substantially more common among sexual abuse survivors than their non-abused peers (Hulme, 2000; Kendall-Tackett, 2003; Raj et al., 2000; Springs & Friedrich, 1992). Women who have been sexually abused often engage in consensual sexual activity at an earlier age, have more lifetime sexual partners, and are more likely to participate in high-risk sexual activity including not using condoms or contraceptives (Raj et al., 2000; Stock et al., 1997). High-risk sexual activity increases the risk for unplanned pregnancies among teens (Raj et al., 2000; Springs & Friedrich, 1992) and adults (Prentice et al., 2002). In a nationally representative U.S. sample of mothers of children under age three (n = 1220), women with a history of child sexual abuse were more likely to have both an unwanted pregnancy and late prenatal care (Prentice et al., 2002).

Although sexual abuse increases the risk of teen pregnancy, we cannot assume that all teen mothers have a history of abuse. A recent study of 252 pregnant teens from Montreal found that 79% had no reported history of sexual or physical abuse. However, 21% reported multiple forms of past abuse. Only sexual abuse was related to depression during pregnancy (Romano et al., 2006).

The Effects of Poor Health Behaviors, Depression and PTSD on Pregnancy

A history of abuse also impacts women's antenatal health through their behaviors and through the effects of depression and posttraumatic stress disorder (PTSD). In a study from Norway of women with low birth weight (N = 82) and term babies (N = 91), 56% of sexual abuse survivors smoked during pregnancy compared to 31% of non-abused women. Abuse survivors also reported more health problems during pregnancy and used more healthcare services than their non-abused counterparts (Grimstad & Schei, 1999).

Depression and PTSD are common sequelae of both childhood abuse and current intimate partner violence (IPV). As two recent studies found, women suffering from either of these conditions have an increased risk of pregnancy, neonatal complications, and interventions during labor. For example, depressed women have higher rates of preterm birth than their non-depressed counterparts, even when controlling for other risk factors (Kendall-Tackett, 2007, 2008).

A prospective study of 959 women in Hong Kong found that women who were depressed in the third trimester had higher rates of epidural anesthesia, cesarean sections and instrumental vaginal deliveries. Their infants were also more likely to be admitted to neonatal intensive care units. These effects were still present even after researchers controlled for pregnancy complications, showing an independent effect of depression (Chung, Lau, Yip, Chiu, & Lee, 2001).

In a study that compared 455 women with PTSD to 638 without PTSD, Seng and colleagues (2001) found that women with PTSD had significantly higher odds ratios for ectopic pregnancy, spontaneous abortion, hyperemesis, preterm contractions, and excessive fetal growth. While not specifically addressing childhood abuse, these studies nevertheless provide us with a glimpse of some possible health problems abuse survivors may encounter antenatally.

Summary

A history of childhood abuse can increase women's health problems during pregnancy. Common sequelae of past abuse can lead to pregnancy complications and an increased number of interventions during labor, demonstrating that the effects of abuse can last long after the abuse has ended. These complications can also increase women's risk of difficulties during the postpartum period, the focus of the next section.

Postpartum

Women with a history of childhood abuse or current partner abuse are at risk for postpartum mental health problems (Kendall-Tackett, 2005). And neither pregnancy nor the postpartum period offers protection from abuse, as the studies below indicate.

Risk of Current IPV

Three recent, large, population-based studies found that many women are beaten during pregnancy and the postpartum period. In a Chinese study that included 32 communities, 8.5% of women were beaten before pregnancy, 3.6% during pregnancy, and 7.4% after pregnancy (Guo et al., 2004). In North Carolina, 6.9% were beaten before pregnancy, 6.1% during pregnancy, and 3.2% postpartum (n = 2648; Martin et al., 2001). Finally, in Bristol Avon, UK (n = 7591), 5% were beaten during pregnancy and 11% postpartum (Bowen et al., 2005).

At this point, it's difficult to know whether pregnancy vs. postpartum puts women more at risk, as these studies offer conflicting findings. The differences in these results may be due to different subgroups of abusers within the samples. Abuse during pregnancy is especially dangerous and is a risk factor for lethal abuse (Campbell & Kendall-Tackett, 2005). Samples with a higher percentage of women abused during pregnancy may have had a higher proportion of these more dangerous perpetrators.

A study of 570 teen mothers showed the continuity between antenatal and postpartum violence. The prevalence of intimate partner violence was highest at three months postpartum (21%) and lowest at 24 months (13%). Seventy-five percent of mothers beaten during pregnancy were also beaten during their first two years postpartum. And 78% who experienced IPV at three months postpartum had not reported IPV during their pregnancy (Harrykissson et al., 2002).

Lutz (2005) also described the continuity between past and present violence in her qualitative study of 12 women who were survivors of intimate partner violence during at least one childbearing cycle. Among these women, depression, PTSD and anxiety were common. The study participants reported many types of violence during their lives: child physical, emotional and sexual abuse; neglect; parental intimate partner violence and substance abuse; current intimate partner violence; adult sexual assault; and community violence. The women experienced each exposure to violence as influencing and flowing into the next. They viewed intimate partner violence during childbearing as just part of the continuum of abusive experiences in their lives.

Impact of Past or Current Abuse on Postpartum Depression

A study of 200 Canadian women at 8 to 10 weeks postpartum found that women with a history of abuse are more likely to experience both depression and physical health symptoms in the postpartum period (Ansara et al., 2005). A three-year follow-up of 45 Australian mothers with postpartum major depressive disorder found that half had a history of child sexual abuse. The sexually abused women had significantly higher depression and anxiety scores and greater life stresses compared to the non-abused depressed women. Moreover, the sexually abused women had less improvement in their symptoms over time (Buist & Janson, 2001).

In another sample of 53 low-income single mothers, childhood abuse and low self-esteem predicted depressive symptoms, and these symptoms influenced women's reactions to their babies (Lutenbacher, 2002). Everyday stressors, when combined with depression, predicted higher levels of anger in the mothers. But current partner abuse was the best predictor of the mothers' overall abusive parenting attitudes (measured by the Adult-Adolescent Parenting Inventory), and more parent-child role reversal.

The Effects of Poor Partner Support

Women who have experienced previous abuse can have difficult relationships with their partners (Kendall-Tackett, 2003). In a longitudinal study from Avon, UK (N = 8292; Roberts et al., 2004), women who had been sexually abused were more likely than non-abused women to be single parents, cohabitating in their current relationships or step-parents. They also reported less satisfaction with their current partners. Although the study authors are not explicit about this, it seems reasonable to hypothesize that women who report low satisfaction in their relationships do not consider these relationships to be good sources of support. And lack of partner support puts them at risk for both depression and health problems.

Even among non-abused women, lack of partner support increased the risk of postpartum depression. In a study of married women at two months postpartum, spouses' lack of help with childcare and household tasks predicted depression severity (Campbell et al., 1992). Further, spousal support interacted with pregnancy and delivery complications so that women with more complications and lower levels of support were more likely to be severely depressed. In this same study, women with less spousal support were also more likely to be chronically depressed, even up to two years later.

Another study examined the importance of social support with three samples of postpartum women: 105 middle-class white women, 37 middle-class mothers of premature babies, and 57 low-income African American mothers (Logsdon & Usui, 2001). The authors tested a causal model, using structural equation modeling, and found that the women's perceptions of the support they received and their closeness to their partners significantly predicted both self-esteem and depression. These predictors were the same for all three groups of mothers.

VAW and Women's Social Networks

Women in ongoing abusive relationships, or who have a history of abuse, may also have difficulties forming other types of social bonds. The relationship between social support and depression appears to be bidirectional. Lack of social support increases the likelihood of depression, and depression seems to impair people's abilities to make social connections. A recent study (Hammen & Brennan, 2002) sought to explore this relationship in a sample 812 community women. The women in this study were divided into three groups: formerly depressed, currently depressed, and never depressed. (They were not identified by abuse history.) Data were collected from spouses,

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adolescent children and independent raters. Their findings demonstrated that interpersonal difficulties were not simply consequences of depressive symptoms. Women who were not currently depressed, but had been, were more impaired on every measure of interpersonal behavior and beliefs than women who were never depressed. The formerly depressed women's marriages were less stable, and they had lower levels of marital satisfaction. There was more spousal coercion and injury. The formerly depressed women had more problems in their relationships with their children, friends and extended families, and they experienced more stressful life events. Finally, they were more insecure in their beliefs about others. The authors concluded that interpersonal difficulties were a stable component of depression, and that these difficulties were not only difficult to treat, but may make sufferers more vulnerable to future episodes of depression (Hammen & Brennan, 2002).

A similar pattern of problems in social relationships was found in families who were maltreating their children. Gaudin and colleagues (1993) compared neglectful, low-income mothers with those who were low-income but not neglectful. There were striking differences between the groups. The neglectful mothers were significantly lonelier and more socially isolated, they reported more depression, and averaged more than twice the number of stressful life events in the previous year. Mothers in the neglect group reported fewer social ties and had more people critical of them in their social networks. The authors recommended that case workers address loneliness and isolation in these families to help them cope with significant life stresses related to poverty, lack of access to healthcare, housing, and other support services.

The Health Effects of Lack of Support

Lack of support not only increases the risk for depression; it also causes its own set of health problems. Although the studies below did not specifically examine abuse history, the findings are relevant in that lack of support can be another way that past or present abuse impacts women's health postpartum.

In a review, Salovey and colleagues (2000) noted that social support is related to lower mortality and greater resistance to communicable diseases. Among people with good support, there is a lower prevalence of coronary heart disease, and they recover faster following surgery. When faced with stress, those with few social resources are more vulnerable to illness and mood disorders than are people with good support.

A study of high-risk teens admitted to a psychiatric hospital indicated that social support was an effective buffer in some circumstances. The teens in this study had experienced or witnessed high levels of violence in both their families and communities. Social support shielded these teens from some of the effects of family violence. Social support did not appear to ameliorate the negative impact of community violence, however (Muller, Goebel-Fabbri, Diamond, & Dinklage, 2000).

The health effects of social support appear to be especially important people with lower incomes. Low-income individuals with social support had better cardiovascular health and immune function than low-income people without support. These findings did not occur for those with higher incomes (Vitaliano, Scanlan, Zhang, Savage, Brummett, Barefoot, & Siegler, 2001).

Conclusions

Although data are limited on the impact of VAW on women's perinatal health, we do know that women experiencing past or current VAW are at increased risk for depression, PTSD and physical health consequences antenatally and postpartum. However, there are some hopeful signs. Not all women who have experienced past abuse become depressed, end up in unsupportive or abusive relationships, or have difficult relationships with their children. These hopeful signs offer us at least a glimpse of what the perinatal experiences of all abuse survivors could be like. And improving the antenatal and postpartum experiences of women with a history of violence is a goal worth pursing.

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PTSD Criterion A and Betrayal Trauma: A Modest Proposal for a New Look at What Constitutes Danger to Self

Laura S. Brown and Jennifer J. Freyd

Why and how does psychological trauma harm people? The traditional assumption in trauma research has been that extreme fear is at the core of post traumatic responses to events like war and natural disasters. This assumption is at the heart of the PTSD Criterion A definition in the *DSM IV-R*: "witnessed or experienced an event threatening to safety or life." Is terror the only cause of traumatic distress and harm? Some patterns of events (such as sexual abuse by a parent, acquaintance rape, or government mistreatment of citizens) generate strong symptoms of trauma even absent intense fear, perhaps because they involve social betrayal. Betrayal trauma theory (Freyd 1996; 2001; Freyd, DePrince & Gleaves, 2007), drawing on developmental, cognitive, and evolutionary psychology, posits that (a) there is sometimes a social utility in remaining blind to betrayal and (b) betrayal traumas can be particularly toxic.

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In Figure 1 two independent dimensions of trauma are identified as particularly likely to cause psychological harm: the terrorizing and life-threatening aspect of traumatic events and the social betrayal aspects of traumatic events. Recent research has suggested that betrayal may be a particularly potent aspect of trauma when it comes to long lasting harm. For instance, DePrince (2001) discovered that trauma survivors reporting traumatic events high in betrayal were particularly distressed. Freyd, Klest, and Allard (2005) found that a history of betrayal trauma was strongly associated with physical and mental health symptoms in a sample of ill

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individuals. Similarly, in a recent analysis using the Adverse Childhood Experiences (ACE) data set, Edwards et al. (2006), reported finding that high betrayal participants had poorer health and social functioning and poorer mental health than other abused participants.

The Ethics of Diagnosing Trauma-Betrayal as a Factor

Consideration of the effects of betrayal on the experience of trauma raises important questions about how a clinician conceptualizes what constitutes a Criterion A event for an individual. We would like to suggest that the willingness, or failure, to consider the meaning of betrayal may constitute an ethical dilemma for clinicians.

Diagnosis is rarely conceptualized of as an ethical process. Normally, diagnosing someone's distress or dysfunction entails matching symptoms to the lists of criteria in the *DSM-IV*, and naming the problem by how it best fits those criterion sets. People will often be given more than one diagnosis, and even when a prior diagnostic label is eventually determined to have been incorrect, it is rare that any sort of backward corrective process ensues; an erroneous diagnosis can follow someone, along with psychiatric records, for life, coloring how they are perceived and treated by both mental health and medical care providers. Diagnosis is one of the powers of the clinician; like any power, it is subject to abuse, and like any power of an institution of the larger society, at risk of being affected by the politics of that greater context.

Because diagnosis is both an ethical and a political undertaking, diagnosing has the potential either to silence and disempower suffering humans, or to create an experience of visibility, voice, and empowerment. The framework of Betrayal Trauma Theory (BTT) offers an important window through which to analyze how certain categories of adult experience entailing interpersonal betrayal can be understood as types of trauma exposures. In this article we discuss the political and ethical implications of agreeing, or refusing to give a diagnosis that is congruent with a person's lived experiences of distress, and consider the implications of BTT for understanding how an experience might meet Criterion A.

How is diagnosis an issue of ethics? Leaving aside formal ethical considerations regarding competency to diagnose, let's begin by discussing how diagnosis is an authoritarian act on the part of a psychotherapist. As Brown and Ballou (2002) argued, "…we see that the decision to call nonconforming thoughts, values, and actions psychopathology does two things. First, it discounts she or he who is described as such. Second, it blocks our ability to look outside the individual to see forces, dynamics, and structure that influence the development of such thinking, values and actions" (Brown & Ballou, 2002, p. xviii).

Consider the ethics of discounting and misperceiving. If the capacity to be emotionally present is defined as a form of competence in psychotherapy practice, then engaging in a process which is inherently invalidating, as diagnosis can be for many of those receiving such a label, might be considered to ethically problematic, and deserving of scrutiny. The clinician making the diagnosis generally operates out of a number of non-conscious and usually unchallenged biases about what kind of experience falls within the range of psychopathology, and what constitutes "normal." Assumptions are made by the clinician as to the persistence of a behavior from past times, as to its hypothetical biological basis, as to its prognosis for responding to a particular intervention. Most of this is done from a stance privileging the clinician's standpoint as objective and neutral, and that of the client or patient as skewed by the very distress for which she or he seeks assistance.

Going to the second point raised by Brown and Ballou (2002), and related to this first topic, is the tacit inattention paid by the diagnostic process to the external social realities of people in distress. This is a sort of anti-ethical stance inherent in our current formal diagnostic nosologies; it is a politic of defining distress as an internal, individual experience for which social realities are meaningless. If a person meets criteria for Major Depression, Single Episode, Severe, the contributions of those social realities are not taken into account, or seen simply as one of many Axis IV psychosocial stressors that somehow contribute to the expression of this "real" thing, the Depression. If a person has the symptoms of being traumatized, but lacks an apparent Criterion A event, then they cannot have PTSD, and so their distress will be named in such as way as to obscure the presence of anything experienced as traumatic.

The Trauma of Exploitation and Betrayal

One of the groups of people for whom these ethical ramifications of diagnosing and naming distress as trauma—or not trauma—is particularly salient are people who have experienced betrayal as adults in professional relationships of care. Since the middle 1970s, the growing scholarly literature about people who have had this experience has commented

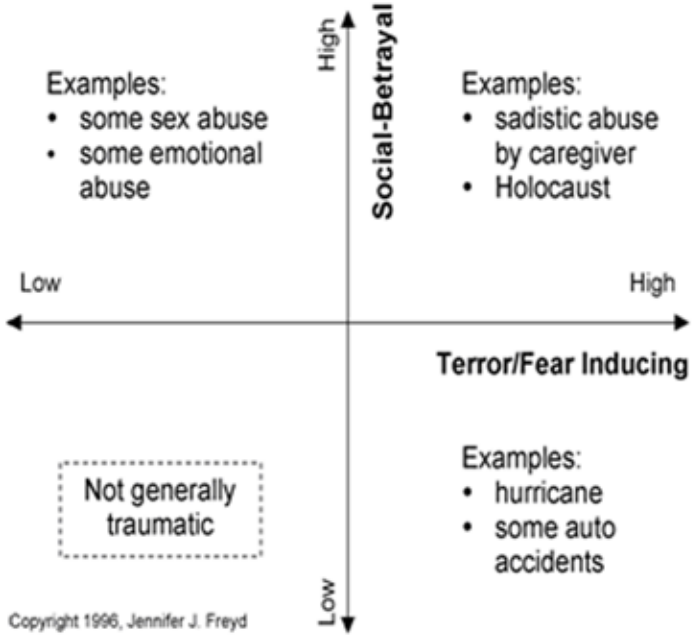

Figure 1. The two-dimensional model of trauma. ©Jennifer J. Freyd, 1996. Reprinted with permission.

on the resemblance of symptoms following sexual exploitation to those following exposure to a Criterion A traumatic stressor (Brown, 1992; Pope, 1994; Schoener, Milgrom, Gonsiore, Leupker, & Conroe, 1989). Persons who, in adulthood, have experienced sexual exploitation by health care providers, psychotherapists, clergy, and others in positions of power, care, and responsibility report intrusive symptoms, emotional numbing, and autonomic hyperarousal in the aftermath of these forms of violation, just as if they had been exposed to a threat to life or personal safety.

However, because most such experiences have not involved threat or force, and are more likely to have taken place within a narrative of love and forbidden romance, the presence of PTSD-like symptoms has been a challenge to clinicians who feel themselves bound by the parameters of the diagnosis as laid out in the *DSM*. This becomes more salient because some unknown percentage of these survivors makes a decision to bring a formal complaint or file a civil lawsuit against the professional who has violated their trust. This, in turn, places the question of what name to call their distress into the legal arena, where an attorney for the professional, or their employer, will call all aspects of the survivor's narrative into account, including the diagnosis given by any subsequent treating clinician.

Attorneys, not trained as psychotherapists, are frequently *DSM* fundamentalists, treating the book as a form of holy writ that cannot be gainsaid. Clinical judgment, the notion that one might consider the meaning of an event to a person's life in determining the appropriate diagnosis, seems to be an incomprehensible idea to many attorneys encountered by the first author in her forensic practice. If the description of Criterion A is "witnessed or experienced an event threatening to safety or life," then that event should be one that is obviously frightening, right? And how was having sex with her priest frightening to this adult woman, the attorney asks the psychologist? In the days of the original iteration of Criterion A, which described trauma as an "event outside the range of usual human experience," it was not unheard of to encounter attorneys who would, after eliciting testimony that sexual abuse of children was not an unusual or uncommon event, would then challenge a PTSD diagnosis given by a mental health professional on the grounds that sexual abuse of a child did not meet Criterion A.

This diagnostic fundamentalism is not entirely confined to attorneys, however. During the memory wars, when every survivor's account of childhood abuse experiences was being treated as false because of the absence of witnesses or corroboration, clinicians working in some settings found themselves frequently being required to change a PTSD diagnosis to something else because no one actually knew whether the trauma had taken place.

Consider the potential ethical issues inherent in this conundrum. A person experiences an event that feels traumatic to them. Force and threat of force were not used; grooming, which resembles romance, manipulation, and abuse of power were all present, however. For a clinician to silence the experience of the survivor of this sort of experience by denying its traumatic realities is an ethical stance; it is a decision to go along with what is officially correct rather than to situate oneself as an ally to the person who has suffered the violation of trust.

Betrayal Trauma Theory (BTT) offers an empirically-based theoretical model which supports the reality that non-violently exploited individuals have experienced trauma, and calls into consideration how we define a Criterion A event. The BT model posits that betrayal traumas are traumatic emotionally for humans when the extent of the betrayal becomes knowable. Similar to Koss's (1990) conceptualizations of how acquaintance rape is traumatic, wherein the experience becomes overtly perceived as traumatic after the victim reappraises the meaning of the experience from merely unpleasant to one of violation, the BT model tells us, not only why memories for childhood abuse can become elusive or unavailable for many years, as was its original goal, but also why experiences that are confusing or unpleasant, but not an immediate cause of fear, horror, or sense of danger to life, can become traumagenic for people. The betrayals of trust that can occur in contexts where people can reasonably assume that a powerful other is looking out for their interests and welfare are also a form of shattered assumptions; thus, a betrayal trauma does not require a family relationship of care-giving in order to occur so long as there is a reasonable expectation that the other person will have a commitment to one's welfare, safety, and well-being.

Sexual exploitation of adults by psychotherapists, health care providers, attorneys, and clergy represent precisely this sort of scenario. Individuals in each of these professions have made commitments, either explicitly, via the ethical codes of their respective disciplines, or implicitly (as with clergy), within the framework of a particular religious code of morality, to care for the welfare of others with whom they have professional relationships and to place that welfare above the satisfaction of their own desires. Physicians, attorneys, therapists, and clergy are, consequently, given social powers not available to others. Health care professionals may touch their patients' bodies, psychotherapists, clergy, and attorneys elicit secrets about very distressing and shameful life events; all of these are bound, in some manner, to maintain the confidentiality of what has been revealed.

These institutionalized forms of relational power do not require that those holding them actually have feelings of care for the individuals in their keeping, although such care is also implicit in these relationships, and commonly present. However, because of the existence of this implicit expectation of actual caring, many people form symbolic relationships with people in these powerful roles that evoke the parent-child relationship. As the justices of the 9th Circuit Court of Appeals noted in the case of Simmons v. U.S., where a woman sued her psychotherapist who had sexually exploited her, the presence of that symbolic, transferential relationship, makes the sexual encounter between a therapist and client (and, for purposes of this paper, between other powerful caregivers and their patients, clients, and congregants), not simply one of adult to adult.

As is true in the relationship between parent and child, the professional in a relationship with an adult client or patient also holds the power to convey information. This is, once again, an ethical stance. One can practice an ethic of

continued on p. 14

continued from p. 13

enhancing client or patient autonomy by sharing maximum information, or an ethic of protectiveness by withholding information deemed by the professional to be potentially harmful. But harmful to whom? In most cases where a professional sexually exploits someone, that professional is very likely to know that their own discipline proscribes this behavior because it is known to do harm. In almost every instance that has been documented in legal cases or scholarly literature, exploiting professionals have withheld that information from the person whom they were grooming for their own sexual use.

Indeed, for many of these exploitative professionals, the abuse of the power of their role included the generation of misinformation as part of the grooming process. Survivors of exploitation have described being told that this relationship, because it was actually love, and thus was special, or was therapeutic in some manner for the client, would not lead to harm. Many of the professionals who perpetrated these violations told their victims that the norms and rules of the profession were not truly about protecting clients, but were actually about blocking their autonomy, or about undermining the potential for genuine mutuality between two kindred souls who had just happened to meet in the context of a professional care-giving relationship. In some cases of abuse of adults by clergy, the rationale given for breaking the rules was that the sexual relationship was an expression of divine love.

BT Theory helps clarify several ways that this scenario is traumatic, and can lead to post-traumatic forms of distress in its survivors. First, as Freyd (1996) has noted, in relationships of dependency and love, one's cheater detectors are frequently ignored in favor of one's attachment needs. It should not be surprising that many of the people exploited by professionals as adults were also sexually abused as children, not, as Kluft (1990) once argued, because they are "sitting ducks" for the next perpetrator (cite), but rather, as BTT would suggest, because they have already over-learned to privilege their attachment needs when those are placed in conflict with needing to know the truth about abuse. Exploitative professionals, consequently, re-invoke earlier betrayal traumas in many of their victims They may or may not lie explicitly to their clients, patients, and congregants as they groom them, but they almost always withhold the information that what is about to ensue is likely to damage the less powerful party in innumerable and long-lasting ways.

The reappraisal of what has occurred as a violation, buoyed up by a fabric of lies and deception, represents what we would argue constitutes the Criterion A event of a betrayal trauma. This reappraisal happens in many ways, but in each instance, the exploited person comes to realize that what has happened was not love, or caring, or being special, but was in fact an experience of being used, lied to, and betrayed. For many adults who are exploited in this way, the phenomenology of having been betrayed is a conscious one; survivors will use the term explicitly when referring to what happens when they become aware that their therapist, physician, attorney, or clergy person has betrayed, not only the rules of their respective disciplines, but also the implicit relationship of caring that the exploited person reasonably expected them to offer as part of the professional relationship.

For survivors of sexual exploitation by psychotherapists this experience of betrayal can be experienced as an especially traumatic event. As one survivor put it eloquently to the first author, "I expected my family members to sexually abuse me. They were horrible people, dangerous people. But I expected a therapist to be safe. All of my therapists before him had been safe. Now it feels like there's no safe people, and no safe place." The individual whose just world expectations have been shrunk by childhood trauma and abuse, leaving professionals as the sole people in whom trust can be placed, experiences a shattering of those expectations arising from professional betrayal that is profound and soul-shattering. Such a person has not experienced an event that physically threatened their life. She or he has, nonetheless, experienced an event that phenomenologically was experienced as life-threatening.

A New Way of Conceptualizing Criterion A

BTT allows the clinician to formally define that inner experience of trauma in a way congruent with the survivor's experience. Rethinking Criterion A in this way offers a framework that does not discount the lived realities of the exploited adult whose beliefs about the categories of people who can be trusted, and the trustworthiness of the particular professional who has exploited them, have been blasted by the realization that betrayal has occurred. This, in turn, brings us back to the ethics of diagnosis, and to questions of whether an event such as sexual exploitation of an adult by a professional can lead to the development of PTSD.

We would like to argue that BTT provides an empirically derived additional pathway toward a Criterion A event. When an individual experiences a BTT Criterion A, a cognitive appraisal of having been betrayed in a relationship of trust and care, that individual has experienced trauma. The pervasiveness of PTSD symptoms in the population of people who have been sexually exploited in this way is simply a reflection of a reality; the exploited person has experienced betrayal, and betrayal is experienced as deeply endangering to safety, even when physical realities appear to be free of threat.

To name the distress of the exploited person as trauma-related is, consequently, an ethical stance of aligning the diagnosis with the client's lived, felt experience. It is also a step toward challenging the notion that trauma is simply about fear, and toward the stance that trauma is also about the disruption by betrayal of necessary attachments and dependency relationships. The ethics of founding diagnostic categories in a reality that ignores the importance of attachment to human welfare constitutes another article, but the use of BTT as a paradigm for conceptualizing how the disruption of attachment and dependency by betrayal illuminates the problematic nature of a fear-only basis for understanding what constitutes trauma.

An ethic of empowering the survivors of trauma includes using the diagnostic power of the clinician to make their pain visible and knowable. BTT empirically supports the use of a post-traumatic diagnosis with survivors of adult experiences of sexual exploitation by professionals and care-givers. This paradigm for a Criterion A event enables a clinician to take the ethical stance of allying with the survivor, rather

than conforming concretely to the fear-based constructions regulating the current definition of Criterion A. The task, now, is on-going engagement with those defining trauma, so that the effects of disruptions of attachment and dependency by betrayal, and Betrayal Trauma as a powerful form of traumatic stressor, are included in the diagnostic canon.

Future Questions

Our proposal generates a number of questions that can, and should, be empirically studied so that the potential inherent in the impacts of betrayal as a traumatic stressor for adults can be more completely understood. Is the traumatic harm necessarily associated with appraisal of betrayal, or with the betrayal itself? This is an empirical question worth demanding research. As noted by DePrince and Freyd (2002):

> The role of betrayal in betrayal trauma theory was initially considered an implicit but central aspect of some situations. If a child is being mistreated by a caregiver he or she is dependent upon, this is by definition betrayal, whether the child recognizes the betrayal explicitly or not. Indeed, the memory impairment and gaps in awareness that betrayal trauma theory predicted were assumed to serve in part to ward off conscious awareness of mistreatment in order to promote the dependent child's survival goals....While conscious appraisals of betrayal may be inhibited at the time of trauma and for as long as the trauma victim is dependent upon the perpetrator, eventually the trauma survivor may become conscious of strong feelings of betrayal. (pp. 74–75)

We assume here that the appraisal does in fact usher in a psychological crisis that should meet criterion for PTSD. But what about prior to that appraisal—is the event not problematic? Is betrayal blindness and its psychological sequelae an important contributor to the psychological harms experienced by adults who are betrayed? We assume the event that can eventually cause a crisis when fully appraised, is harmful even before then in profound ways, but that harm has a different flavor. Depression, substance abuse, dissociation, and other manifestations of keeping information out of awareness, are very likely present. Is the experience of childhood betrayal trauma a factor contributing to vulnerability to exploitation in adult life?

Should we change Criterion A or advocate a more radical transformation? Kahn (2006) notes "Our clients' most frequent presenting problems are not the many symptoms of PTSD, but rather their failed or failing relationships" (Briere, 2002). In addition to relationship problems, traumatized clients struggle with depression, anxiety, and substance abuse. Why do we have only one explicit trauma diagnosis in the *DSM*? In addition to incorporating betrayal into PTSD criterion A, we urge an expansion of our conceptualization of post (betrayal) traumatic reactions to other forms of distress, including depression, anxiety, dissociation, personality change.

Our call to reconsider what constitutes a Criterion A event by foregrounding the meaning of relational betrayal in the phenomenology of trauma implies the need for a more general and far-reaching discussion of how trauma is conceptualized, something that we consider an ethical dilemma because it brings into sharp focus the ways in which clinicians and researchers use our power to privilege or silence certain kinds of experience as meaningful in the development of psychic pain. It is clear, both for children and adults abused by caregivers, that the betrayal element of these violations begins to have negative consequences fairly quickly. However, none of these other symptoms are formally considered traumagenic in nature, and some authors have criticized those who point to trauma as a risk factor for a wide range of forms of distress. We believe that the empirical data about the effects of relational and attachment violations and betrayal warrant such reconsiderations, and re-openings of discussions of the larger contributions of trauma to human difficulties.

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Preparing Students for Trauma-Focused Internships

Gabriela Bronson-Castain, MA
Pre-doctoral Intern
John F. Kennedy University

Gabriela Bronson-Castain, MA

Last year, on applying to APPIC pre-doctoral internships, I had just two criteria: to work with children and to work in the field of trauma. I was fortunate to be matched to my first choice internship and began the internship feeling that I would be adequately prepared. I had focused my practica experience on work with trauma populations, I had taken a class on trauma, and I had done additional readings on trauma. However, when I started my internship in July, the first three months were hectic and near overwhelming. I spent much of my time learning medical paperwork while managing a busy schedule. But, above all, it was the clinical work with an intensely traumatized population that led me to wonder, "Am I really prepared for this?"

Internship is viewed as a time to get your feet wet, but being exposed to new theoretical concepts and working with a trauma population has proven to be a challenge despite my prior training. Understandably, my doubts and concerns are common amongst pre-doctoral interns, but I wondered what advice training directors would like to give to their future interns in order to be better prepared for a trauma internship. I therefore decided to do some investigating in the form of a survey. Some of the responses and my conclusions are provided in the article below.

A survey was emailed to 266 internship site training directors across the USA who had identified "Trauma" as a major focus of their training program on the APPIC on-line directory. Of the 266 training directors emailed, 61 responded to the query. Responses came from a wide range of internship sites serving a range of adults, children, adolescents, ethnic minorities, veterans, geriatrics, LGBT, deaf/hearing impaired, disabled, students, immigrants, refugees, urban, low-income, and homeless populations (see Figure 1).

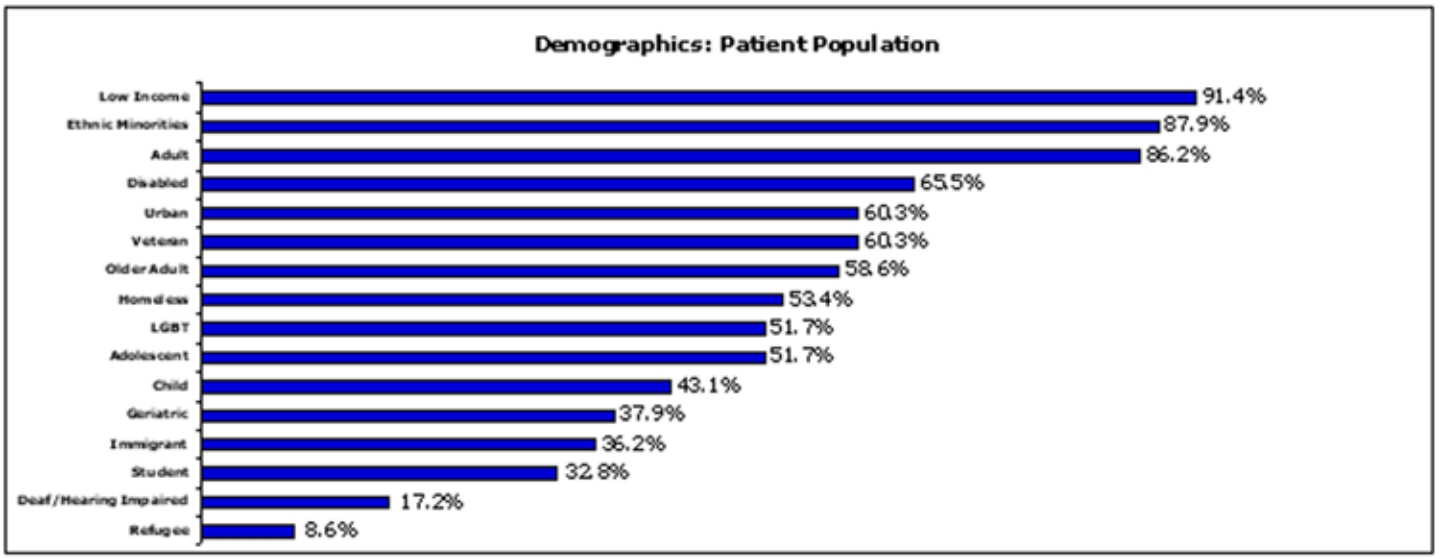
The survey consisted of open-ended questions focusing on three components: the trauma-related experience level of interns (past and present), what training programs expected incoming interns to know, and how future trainees could be adequately prepared for internships working with trauma populations. Training directors were asked to respond to the following questions:

1. Do you feel that your interns (past and present) are academically prepared to work with a trauma population?
2. In what ways can your interns become more academically prepared for your training program?
3. Do you require your interns to take a trauma related class before they begin their internship? If so, which one(s)?
4. In addition to required classes, which elective classes would you like to see your interns take?
5. Does your training program practice and/or teach a particular model of trauma treatment? If so, what is it
6. How can future applicants prepare for an internship working with a trauma population?

Readiness Level for Trauma Work

There were mixed responses on whether interns are academically prepared for working with trauma populations. Twenty-eight percent of the training directors surveyed believed that their interns were not prepared for working with trauma populations. One director said, "Almost all of our interns come with minimal knowledge, training, and experience about trauma work and working with trauma-related symptoms." Thirty-seven percent of directors surveyed stated that the experience varied from intern to intern. Some interns come in with direct clinical experience in the field of trauma, and others have a solid theoretical trauma foundation. Thirty-five percent of directors declared that their interns were academically prepared (see Figure 2). At the same time, the expectations of training directors and the intensity of clinical work in trauma varies from program to program. One director reported a common sentiment, "Generally having good basic clinical skills is enough; we take it from there."

Figure 1

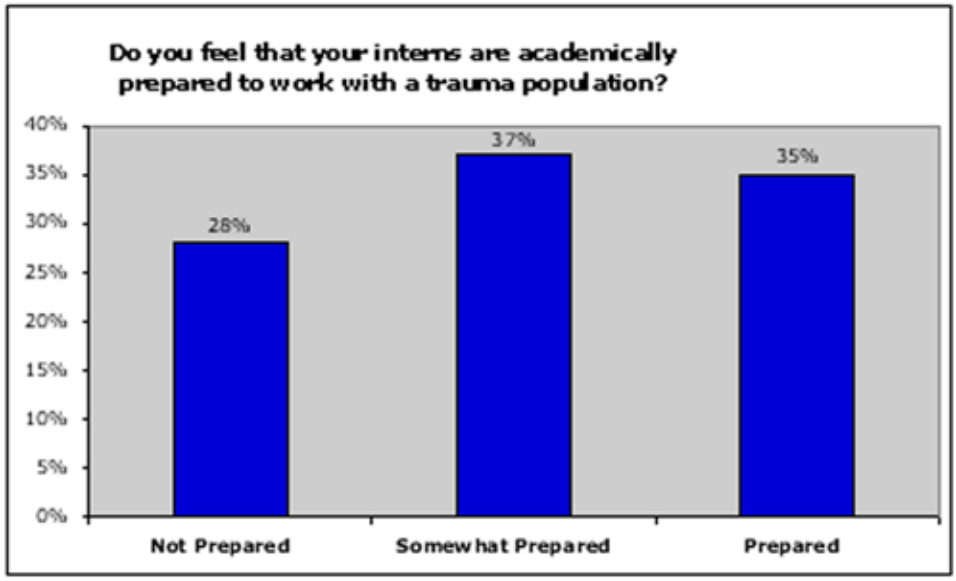


Prerequisites for Trauma-Focused Internships

While no internship site required their trainees to take a trauma-related class as a prerequisite, a subset of training directors said they would like to make this a requirement if trauma courses were readily available to the students. When asked which models of trauma treatment are taught and practiced within their internship program, 40% identified specific treatment modalities such as Dialectical Behavioral Therapy (DBT); Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Assessment, Crisis Intervention and Trauma Treatment (ACT) and Prolonged Exposure Therapy (PE). In conjunction with this question, training directors were also asked which elective classes they would like to see their interns take prior to internship. In addition to classes on the treatments listed above, training directors wanted more classes on the treatment of PTSD, complex PTSD, the neurobiology of trauma, dissociation and psychosis, and trauma assessment measures. One training director recommended, "[Taking a] class on the relationship between trauma to related disorders and disturbances; a class on therapeutic approaches to patients whose disorders are linked to trauma; class(es) on objective and projective psychological assessment of trauma-related issues and disorders." A handful of directors focused less on trauma-related diagnoses and treatments and more on knowledge about the trauma populations being served. For example, several sites working with children and adolescents responded that they wished their interns had the opportunity to take advanced classes on developmental and child psychopathologies. Others wished that their interns had taken coursework related to domestic violence, immigration, sexual assault, and training specific to treating trauma in marginalized communities. Another director recommended, "More courses on working with special populations such as ethnic minorities, traumatized patients with differential diagnoses, and psychotherapy for personality disorders."

Training directors have varied opinions on what they expect their interns to know at the start of a training year. One of the most frequent complaints was directed towards academic institutions. Training directors are keenly aware that trauma classes are not a core component of most psychology curricula and are often integrated into other classes. Moreover, graduate school programs do not offer a wide array of trauma-related courses. One director reported, "Many academic programs address this issue [trauma] in their courses but do so from a "survey" approach, rather than an intense academic focus." To offset this lack of focus, many internship sites suggest that students gain experience with specific trauma populations and trauma treatment modalities during their practica years. If trauma-related courses are not available, training directors suggest attending a conference, seminar, or workshop to supplement trauma training. Lastly, even if courses and seminars are available, several directors suggested students familiarize themselves with such authors as Courtois, Foa, Herman, Horowitz, and Keane prior to beginning internships. One training director said, "I think universities are slowly moving toward addressing the need for their students to be aware of the evidence-based and empirically-validated treatments that are out there, but just not fast enough!"

Figure 2



Recommendations for Future Interns

The motivated intern will need to gain the experience and education required to successfully navigate both the application process and the internship year. The following is a summary of training directors' recommendations that may provide some guidance for students preparing for internship:

- Take classes specifically geared toward working with trauma populations as early in your graduate career as possible. In addition, attend conferences, seminars, and workshops in order to supplement academic experience.
- Read the current trauma literature. Know trauma theories and have a solid foundation in the theoretical orientations your desired internship sites use.
- Many sites do not see all trauma-related experiences as universally similar. For example, experience with child sexual abuse may not adequately prepare a student for working in a veteran's hospital. Once again, contact your desired site to get a better understanding of what practicum experiences will be most useful.
- Learn about evidence-based treatments.
- Advocate for more trauma-related classes in your academic programs.

I would like to thank all respondents to this survey. I am aware that training directors regularly receive surveys and must carefully select the surveys they respond to (particularly during the APPIC application process). I have received feedback from many directors who have wanted a forum to express their views and concerns on this matter for some time, and who are very interested in how to improve the experience of their interns going forward. As a follow-up to this article, I will be offering students the opportunity to comment on their experiences of becoming prepared for trauma-related internships. Results of this survey will be available in the upcoming edition of Trauma Psychology. If you are interested in participating in this survey, please contact me at gbcastain@jfku.edu. If you are not currently a student member of Division 56, you can join today for the low annual rate of $10 at apatraumadivision.org. If you have any questions about student membership or joining the student committee, feel free to e-mail us at apadivision56jill@gmail.com.

Membership Committee

Sandra Mattar, PsyD

Call To Members

Sandra Mattar, PsyD

The Membership Committee (Div. 56) chaired by Sandra Mattar, PsyD, is actively looking for Division 56 members to join its ranks. We would like to identify representatives from each state in the United States, as well as international members, to join our committee. The state or country representatives would be in charge of recruiting potential members to join Division 56. There are no particular requirements for the job, except for being a current member of the division. Your job responsibilities are to recruit members and to provide feedback to the Membership Committee on ways to improve our function within the division. You should also participate in one Membership Committee meeting during the APA Convention. The only requirement for application is your wish to work on behalf of the division and to help the division fulfill its mission.

If you are interested in working with the division, please contact Sandra Mattar indicating which state or country you would like to represent at the following email address: smattar@jfku.edu. You can also call her with questions at (925) 969-3405.

Convention Programming Committee

Our Sincere Thanks

The Division of Trauma Psychology, particularly Convention Program Co-Chairs, Drs. Joan Cook and Richard Thompson, would like to extend their sincere thanks to the following 2008 abstract reviewers:

Tatyana Biyanova, PhD
Diane Bloch, PhD
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Chris Weaver, PhD
Cindy Weisbart, PsyD
Tisha Wiley, PhD

Their thoughtful, timely feedback was instrumental in helping us put together a fantastic program for this year's convention in August.

Special Interest Groups (SIG) Committee

Harold D. Siegel, PhD, Chair, Dissociation SIG

Dissociation SIG Launches

Harold D. Siegel, PhD

The Dissociation Special Interest Group, formally approved on August 17, 2007, in San Francisco, is up and running. We now have over fifty members.

The overall purpose of the SIG is to study the development of post-traumatic dissociative mechanisms. Another goal of the SIG is to keep members abreast of developments in the field of dissociation, including, but not limited to, developmental theories, diagnostic techniques, and treatment methodologies. We also want to have the opportunity to explore the rich history of the dissociative field, particularly with respect to Dissociative Identity Disorder (DID), formerly known as multiple personality disorder.

There was a great deal of excitement about the Dissociation SIG at the annual meeting of the International Society for the Study of Trauma and Dissociation (ISSTD) in Philadelphia in November. It was announced to attendees at the organization's "Town Meeting."

APA approved a listserv; it is now functional and available for members of the SIG to subscribe to. One of our projects for early in 2008 is the premier issue of a newsletter.

If you have ant questions, or wish to join, email me at: ProfDD@aol.com.

Nominations and Elections Committee

Judie Alpert, Chair; Jennifer Freyd; and Charles Figley

The Nominations and Elections Committee is delighted to report that the slate for division officers is complete. We have a wonderful slate. It follows:

President-Elect
Laura Brown
Terence Keane

Member-at-Large
Priscilla Dass-Brailsford
Amber Douglas
Harriette Kaley

Professional Affiliate Representative
David Albright
Toby Kleinman

The elections will take place in April 2008. Elected offices shall assume their position on January 1, 2009.

Science Committee

Jennifer Freyd, PhD, Chair; Lisa D. Butler, PhD; Catherine Clara Classen, PhD; David H. Gleaves, PhD; Terence M. Keane, PhD; Mary P. Koss, PhD; Sarah E. Ullman, PhD

Note: The following letter, dated December 10, 2007, was e-mailed to Strategicplanning2@mail.nih.gov and was "signed" by the Science Committee, listed above. Full text of the strategic plan draft can be found at http://dynamic.uoregon.edu/~jjf/articles/science05.pdf

Dear Colleagues,

Jennifer J. Freyd

We are writing in response to your call for comments on the November 20, 2007 draft of "The National Institute of Mental Health Strategic Plan."

Numerous epidemiological studies indicate that a majority of American adults in the general population have experienced some sort of traumatic event (i.e., death of a loved one, major motor vehicle accident, natural disaster, assault, child abuse). Experiencing trauma—particularly violent, chronic, and interpersonal trauma such as child abuse, rape, and combat—is associated with a host of psychopathological outcomes, including anxiety, depression, suicidality, dissociative disorders, psychosis, personality disorders, substance abuse, severe interpersonal problems and physical illness. This fact—that trauma exposure is empirically associated with psychopathology—has been documented in hundreds of research studies employing diverse samples and multiple methodologies.

Thus, identifying risk factors for, and protective factors against, psychopathology associated with trauma is imperative from a public health perspective. Moreover, understanding the mechanisms by which trauma disrupts mental health will certainly lead to insights and directions regarding treatment. See the attached one-page policy forum published in Science in 2005 regarding the impact of child sexual abuse (CSA) on health and the urgent need for research funding. As this paper illustrates, the associations between trauma and health outcomes have been confirmed in large scale community and well-patient samples after controlling for family dysfunction and other risk factors, in longitudinal investigations that measure pre- and post-CSA functioning, and in twin studies that control for environmental and genetic factors. Similarly, research demonstrates that this particular form of trauma markedly interferes with the healthy development of numerous cognitive, affective, relational, neurological, and hormonal systems. Our understanding of the mechanisms of harm for this trauma and others is in its early stages. There is a pressing need for more research to elucidate these processes and translate mechanistic understandings into effective interventions.

We strongly recommend that traumatic events that capture the impact of combat, domestic and community violence, and especially interpersonal sexual and physical assault be explicitly acknowledged and identified as a priority in the strategic plan. The study of these events at all levels of analysis should be considered: at the individual, family, community, and economic levels. While the November 20 draft of the strategic plan does not rule out funding for this essential research, we urge that the role of trauma in mental health be explicitly stated so that the importance of much needed research funding in this area is clearly supported.

Although there is mention of "cultural/ sociodemographic factors," "exposure to toxic substances in utero," and "stress," acknowledgement of the substantial impact of particularly disaster, interpersonal, and occupational trauma on psychopathology is entirely missing. Similarly, just as the draft plan plainly identifies the need for studies on the impact of genomic variation on mental disorders, we urge that the plan also identify the need for studies on the impact of trauma exposure on mental disorders, including the mechanisms underlying those effects and translating that knowledge into effective treatments. There is substantial work to be done on trauma and violence exposure as a mechanism for the development and exacerbation of mental disorders.

We hope you will explicitly recognize the extensive body of scientific evidence documenting the role of trauma/violence exposure in mental health. Research is urgently needed on the biopsychosocial mechanisms linking trauma exposure to mental health, and this critical area should be an explicit part of the NIMH's mission and strategic plan.

Reference

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International Committee Report

Elizabeth Carll, PhD, Chair

Resource Listing of International Trauma Training Programs

The International Committee is developing a Resource Listing of International Trauma Training Programs. This will serve as a resource for members and other visitors to the website who are interested in international trauma issues. If you have recommendations for international training programs in trauma to be included in the resource list, please contact Elizabeth Carll at ecarll@optonline.net or 631-754-2424 for the possibility of including it in the resource listing.

Elizabeth Carll, PhD

IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

In an effort to keep members updated on important developments in international policies and guidelines, the following is a summary of the launch of the *Interagency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings* which took place at the United Nations in November 2007.

I had the opportunity to participate in the 2005 New York City consultations which were organized to examine, evaluate, and offer input on the proposed preliminary drafts of the content of the guidelines. Consultations were held in various U.S. and international venues. I also attended the recent launch at the U.N. (in my role as a representative to the U.N. from ISTSS), which was an informative briefing and update for the non-governmental organizations (NGOs) and U.N. staff, and was the culmination of several years of intensive consultation and review.

The IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings is a collaborative effort of U.N. agencies and civil society and coordinated by the World Health Organization (WHO) and InterAction, a consortium of 160 U.S. based NGOs. The IASC was established in 1992 by the U.N. to facilitate coordination of response to humanitarian emergencies.

A comprehensive and long term review process was undertaken to achieve global support for the adoption of the comprehensive guidelines which provide a minimum framework of action for the many agencies and responders often involved in the aftermath of large-scale disasters. Having comprehensive guidelines in place is proactive, as often weak coordination of services in the wake of disasters may lead to further problems down the road.

The IASC Guidelines focus on the need to strengthen coordination of necessary services in the wake of disaster, such as mental health and psychosocial services, as these overlapping services are often under separate auspices. In addition, the guidelines can be used to advocate for services for particular populations or needs.

The Guidelines also provide a consensus of action which is important in order to have governments buy into the responsibility to support and fund disaster intervention. The importance of integrating mental health and psychosocial services into all of the aspects of disaster response, as opposed to separate stand alone interventions, is also emphasized.

A matrix, which details actions for various actors during different stages of a disaster, is included in the guidelines and is associated with a set of action sheets describing how to implement minimum responses identified in the matrices. In addition to the minimum responses listed for each of the domains or functions, a list of comprehensive responses is also indicated for the stabilized and early reconstruction phases. References for additional key resources are also provided. However, the guidelines are not intended to be a cookbook approach, rather to be combined with conducting local situation analyses tailored to the most appropriate interventions for particular communities.

Incorporating mental health services through 11 domains are described and highlight the complex and comprehensive nature of disaster response. The 11 domains include coordination; assessment, monitoring and evaluation; protection and human rights standards; human resources; community mobilization and support; health services; education; dissemination of information; food security and nutrition; shelter and site planning; and water and sanitation.

The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings is an excellent example of the development of consensual guidelines and procedures to support effective collaboration and intervention in the wake of disaster.

The IASC publication can be obtained at http://www.humanitarianinfo.org/iasc/content/products

115th Annual APA Convention in San Francisco, August 17–20, 2007

Save the Date!

116th Annual APA Convention

Boston, Massachusetts

August 14–17, 2008

Report on APA Council of Representatives Meeting

Harriette Kaley, PhD
Observer, Division 56

Wednesday, Aug 15 to Sunday Aug.19, 2007

Overview

It's quite a daunting thing, reporting on a Council of Representatives (COR) meeting that was probably one of the more significant ones that APA has had.

On Thursday, the first day of the actual COR meetings (there had been caucuses, formal and informal, the day before, and a plenary session in which Presidential candidates introduced themselves), important business matters were addressed and things moved along smoothly, but it was clearly the quiet before the storm. Everyone awaited Sunday, when the much-discussed resolutions, variously described as the moratorium resolutions, the APA resolutions on torture, on interrogation and so on, were to come to the floor. In between, there were endless discussions, rumors, meetings, negotiations, crack-of-dawn rewritings, and fast-and-furious dissemination of the latest rewordings. In the end, the discussion on the floor of Council was, in my opinion, thoughtful, respectful and responsible. There was a great deal of procedural complexity, as amendments were presented, amendments to amendments discussed, and people came to the microphone with heart-felt and strongly presented perspectives. Most of the speakers were those who had long been absorbed in the drafting of the resolutions and their alternatives, with an impressive grasp of details and nuances of wording. Everyone, I thought, was tremendously concerned with combing through a terribly complex situation, with passionate advocates on all its many sides, and coming up with a reasonable resolution that addressed the complexities but left no room for ambiguity about APA's condemnation of torture. I thought that had been largely accomplished.

Harriette Kaley, PhD

But when I returned to my computer about a week later, it seemed that very little had been fully resolved after all. Reflecting back on it, I think part of what happened was that those who were most active in shepherding the resolutions through COR had become polarized into two highly opposed camps—certainly no surprise when the issue is as important as this one—and they were speaking mostly to each other, not to the rank and file who vote; but in addition, the parliamentary maneuverings, including proposals, amendments, and still other amendments, had become so complex that it was impossible for most of us at our seats, trying as hard as we could, to follow all the details and nuances of difference as they were being presented fast and furiously on the floor. I personally have had the experience since then of coming to understand better one of the amendments, which was offered on the floor and which we did not have copies of at our desk, so that it was hard to process and to comprehend it quickly without having been involved in its development. I now understand why it was so vital to its proposers, but in the heat and pressure of the moment, that was obscure to me and, I gather, to others as well.

Under the circumstances, the best I can do in this report is recount what happened according to my notes and my memory. It is clear now that powerful currents were somewhat subdued and even obscured during the formal meeting by the constraints of parliamentary process, but they have since surfaced compellingly in other venues, and have continued the impassioned discussion.

Detailed Report

On Wednesday evening, after the plenary session, as temporary representative from D56, I attended a meeting of Divisions of Social Justice (DSJ), in which strategy was discussed for Sunday's resolutions. It was clear that participants were preparing very thoroughly.

The COR meeting opened on Thursday with traditional formalities: eulogies for recently-deceased members, thanks extended all around, announcements of Convention highlights.

The normal reports to COR followed. Executive Director Norman Anderson reported that APA membership is fairly stable but aging, with about 150,000 of us but only 18% of us under 40; and that while we have over $4 million per year in revenue, we are cutting into assets. The Strategic Planning Advisory Group has begun helping identify ways to deal with this. One of the Strategic Plan's top priorities is increasing diversity, so Anderson announced, to applause, that a Chief Diversity Officer for APA is being sought. Major changes in staff were announced: James "Jim" McHugh, Chief Legal Officer; Russ Newman, Executive Director for the Practice Directorate; and Charles L. "Jack" McKay, our Chief Financial Officer, are all leaving. There are technological transitions, with Gary van den Bose, APA Publications Director, masterminding a new electronic search engine that links all our databases. Our primary public face, the APA website, is being rebuilt and relaunched, a $7.6 million process; we are raising the funds by leveraging our assets instead of spending them down. Rhea Farberman, Director of the Public Relations Office, gave a status report about rebuilding the website, with much attention to its goals.

After a break, Council adopted the consent agenda and then moved rapidly through several important but noncontroversial items. During lunch, there was supposed to be another meeting of DSJ, but it seems never to have jelled, though certainly there was a lot of negotiating back and forth informally. After lunch, Jack McKay got a very affectionate tribute; his fitting parting gift was a refurbished vintage brass cash register, all attended by two standing ovations.

Carol Goodheart's final report as Treasurer followed. She reported tightened executive compensation procedures, an increase of $8.2 million in our net assets and a $2.5 million cash flow from our buildings that goes into our operational budget. Our $1 million deficit, she emphasized, could be

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APA Council of Representatives Report

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changed by a "hiccup," and budget review and tightening seems to be going on everywhere. The biggest current project is the "designation" of net assets to fund the website rebuilding, as an investment in our infrastructure.

Jack McKay then gave his final presentation. He first focused on the designation of net assets to fund the $7.6 million website relaunch. He, Anderson, President Brehm, Past-President Koocher and others urged us, successfully, to approve the project, on the grounds that an investment in infrastructure is crucial for "marketing our future", especially for attracting and retaining younger members McKay then gave the budget presentation, once again walking COR through an overview of our real-estate holdings, our long-term portfolio, our capital expenditures and our long-term debit structure (at a 6.01% blended interest rate). Our net assets have gone up to $43 million, membership has been stable but aging, and electronic subscriptions are increasing incredibly while standard publications bring in stable revenue only because we continue to raise prices. We have over 500 employees and, like any typical membership organization, we are labor-intensive, with staff and benefits costs constituting 45% of our budget. McKay noted potential risks: our continued reliance on third party vendors, and the potential impact of Google and other forms of open access on our electronic revenues. In his forecast for 2008-2010, he predicted that we would more or less break even. That led into approving the 2008 budget with a slight deficit for 2007 and a slight surplus for 2008, and approving a dues increase.

After a break, COR approved sending members a bylaws amendment permitting electronic voting. An historic vote then took place on another bylaws amendment: adding to the COR membership the representatives from four ethnic minority psychological associations. Discussion centered around such questions as the impact of voting groups with members who are not APA members, but concentrated on the symbolic value of doing this for previously marginalized groups and helping to reverse the perception of APA as racist. (The Association of Black Psychologists has deferred accepting the invitation for the present.) After COR was assured that "territorial associations" would be added to the wording of the item, it was approved to spontaneous applause. Representatives of the American Association of Asian Psychologists, the Society of Indian Psychologists and the National Latino/a Psychologists Association expressed appreciation, saying that we had shifted history and made space for five organizations to come together and yet retain autonomy.

On that happy note, an executive session began and non-voting members like me left the room.

Sunday's session began with time slots specifically allocated to the "moratorium/torture" resolutions and to the psychopharmacology curriculum.

Before moving to the moratorium issue, Council unanimously supported APA's stance condemning the anti-Israeli boycott of British academics, and two motions passed which were intended to support minorities in psychology. There was then considerable discussion of an item about the curriculum for postdoctoral training in psychopharmacology. While the presentations and discussion were informative about the model curriculum and the model legislation, the controversial aspects centered on how many courses could be taken predoctorally. An amendment failed to remove the 20% ceiling on the number of course that may be taken predoctorally, and then the revised curriculum and the accompanying model legislation were approved. Then Presidential Awards were given, including one to Corann Okorodudu; new initial Fellows were approved; and full reimbursement for ethnic minority COR members was continued. Council then moved to the moratorium-torture-interrogation item.

Doug Haldeman of the Board of Directors (BoD) began by contextualizing the resolution, citing the many meetings we have had on ethics and interrogation, with much agreement and much disagreement, and noting the participation of APA's Ethics Office and various Divisions. Everyone, he noted, agrees that psychologists are prohibited from torturing. The disagreement is about language limiting psychologists to health care where detainees are deprived of rights. There was considerable back and forth as the discussion proceeded. The complexity of procedure was due to the fact that the main motion called for a complete moratorium on psychologist participation in detention centers, and that there were two substitute motions, including one offered by the BoD. There was also another substitute motion offered by a diverse group of Council members and also an amendment to that substitute motion regarding psychologists in settings where human rights are not protected; though the group offering the amendment did not have consensus on that point, they felt it was important to discuss it.

Very intense discussion followed. When the voting finally came, the amendment was soundly defeated, to a call from the back of the room of, "Shame!," As the parliamentary process continued, there was a change to the then-main motion, replacing the word severe to significant, in reference to pain inflicted by sleep deprivation and other forms of torture, and the main motion passed. The motion as passed may found on several sites.

Post-Meeting Reflections

1. One thought that kept being mentioned but that never got directly addressed was that APA can only hold psychologists to its ethical standards if they are members of APA. It is frustrating to realize that many of the psychologists who are believed to have been involved in condemned activities are not members of APA, and we have no jurisdiction over them.

2. Technically speaking, there was little at this meeting directly salient to D56 business. But in a larger sense, this COR meeting spoke to D56's broadest concerns: torture inevitably brings with it trauma. Perhaps even more important, this meeting was directly relevant to the future of psychology, and especially to the APA as an organization.

Personally, I have been around long enough to have seen APA go through some very parlous times indeed: the fiscal catastrophe of *Psychology Today*, the splitting off of the

American Psychological Society, the misunderstanding about executive compensation, among others. I am accustomed to the fissure between scientists and practitioners, between academics and clinicians, to the charges of sexism, racism and ageism. But I have never seen such fierce battling among ourselves about our fundamental sense of right and wrong. As an organization, we have, for all the charges against us of conservatism and corporateness, been in the vanguard on social justice matters. But now, although we all seem to agree on what is just and humane, we seem unable to agree about how psychology can achieve it in a way that is both effective and moral, and the disagreement is leading some to advocate leaving the organization, others to withhold dues, and to very public condemnation of each other. I worry about whether we will be able to hold our house together; I fervently hope that we can, because otherwise there will be no responsible group to speak for all of psychology.

Postscript

I am heartened by the developments, as I see them, since the August meeting. After the initial *sturm und drang*, I have a sense that consensus is developing. Colleagues have said to me that if they had it to do over again, they would vote for the defeated amendment now that they fully understand its implications. Generally, it seems from where I sit, from the listservs I read, that it is becoming more and more clear that psychologists want psychologists to have no part in torture and to the extent that torture seems inevitable in off-site interrogations, to have no part in those interrogations. Questions remain, of course: for example, is there any role at all for psychologists in those sites, or other sites, such as perhaps as health-care providers? It will be illuminating to see what our Divisional Task Force has to recommend. Meanwhile, there is a lot of work going on. As a Division, it is clear that we have a lot to offer because of our concern with the traumatizing effects on everyone of torture and abusive interrogations, and I hope we become an increasing part of the ongoing conversation.

Division 56 Council Meeting Minutes

Friday, August 17, 2007, 5:00–10:00 p.m.
Division 56 Hospitality Suite
San Francisco Hilton

Executive Committee of the Council: Judie Alpert, Bob Geffner, Kathy Kendall-Tackett, Melba Vasquez, Terry Keane, Laura Barbanel, George Rhoades, Emily Jacobs, Steve Gold, Beth Rom-Ryner, Lisa Butler

Council Members Present: Judie Alpert, Bob Geffner, Kathy Kendall-Tackett, Melba Vasquez, Steve Gold, Beth Rom-Rymer, Terry Keane, Laura Barbanel, George Rhoades, Harriette Kaley, Emily Jacobs, Topher Collier, Gil Reyes, Priscilla Dass-Brailsford, Chris Courtois, Jennifer Freyd, Lenore Walker, Sandra Mattar, Charles Figley, Elizabeth Carll, Laura Brown, Anne DePrince, Diane Elmore, Desnee Hall, Nnamdi Pole

Kathleen Kendall-Tackett, PhD, IBCLC

Guests: Bob Welch (APA Education Directorate), Luana Bossolo and Margie Schroeder (APA Practice Directorate), Heather Kelly and Karen Studwell (Science Directorate), Gary VandenBos (Chairman, APA Publications), Kevin Bradley (President, Taylor & Francis),

Welcome and Introduction: Judie Alpert

Judie welcomed the group to the meeting of the Division 56 Council.

Approval of Minutes from Mid-Winter Conference Call

Bob asked for approval of the minutes for the Mid-Winter conference call. These minutes were distributed to Council members in March, 2007. The minutes were approved, and Kathy sent copies again to all Council members after the Council meeting.

Discussion about Task Force on Interrogation, Nnamdi Pole

Nnamdi reported that the Task Force was still in the process of forming. He would like for this Task Force to define the impact of torture for both victims and those who engage in coercive interrogation techniques. Laura Brown agreed that this would be an important focus, especially given our Division's work with the military. Nnamdi indicated that he is in the process of defining the key issues for the Task Force to examine and how much they need to cover. The Task Force is made up of seven members, appointed by the President. Priscilla asked if any student members could be included.

Nnamdi feels that Division 56, and this Task Force specifically, have a unique contribution to make to this topic. Nnamdi hopes that an edited book can come out this Task Force, perhaps the first in a trauma psychology series. He requested funds for Task Force conference calls, copying and mailing.

Judie thanked Nnamdi for his work in bringing this Task Force together and carefully assembling the available research on behalf of Division 56.

Special Interest Groups, Desnee Hall, PhD, Chair

Desnee has been very active in getting the Special Interest Groups (SIGs) up and running. Before summarizing her activities, she asked for a bylaw change that made the Coordinator of the SIGs a voting member of Council. This change was approved.

She reported that there are currently 17 proposed SIGs. Three of these have met all the criteria and are now officially recognized SIGs of Division 56. They are child and adolescent trauma, dissociation, and trauma to post-colonial people. She

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Division 56 Business Meeting Minutes

Saturday, August 18, 2007, 5:00-6:00 p.m.
San Francisco, CA

President Judie Alpert opened the Business meeting and commended the group on how far we have come as a Division in our first year. She indicated that the focus this year has been to get the Division "up and running" and that this has clearly happened. She said that she and Bob Geffner have established three task forces. (Since the task forces will overlap with his presidency as well, both Judie and Bob have worked together on the formation of the task forces.) First, she reported on the formation of a task force on Interrogation, chaired by Nnamdi Pole. A second task force is on the , which will be chaired by Dan Brown. She reported that we want this second Task Force to have input on the , which is being developed by the American Psychiatric Association, and we also want to get other groups within APA involved in giving input. Judie mentioned that the is scheduled to be completed in 2012 and will be available for comment in 2009. We need to provide input on the trauma-related diagnoses in the . The American Psychological Association needs to be involved in this process, especially since no trauma-focused committees have been formed. The third task force was formed at the meeting of the Executive Council. It will address trauma and the military: specifically, what we know, what we need to know, and where we need to do in order to reduce trauma in military personnel and their families.

Kathleen Kendall-Tackett, PhD, IBCLC

The current membership for the Division is 1,150. Last year at this time, it was 750. Judie introduced Sandra Mattar, Chair of the Membership Committee. Sandra indicated that she would like other Division 56 members to join the Membership Committee. She would like to establish membership chairs in each of the states who would be responsible for increasing membership in that state.

Contributions and Fundraising

Judie announced that Melba Vasquez and Terry Keane have spearheaded efforts to raise contributions to cover the expense of the Division hospitality suite. There will also be a silent auction in which books on trauma, which have been authored and donated by Division members will be sold, at the dessert reception. This fundraising event is co-chaired by Emily Jacobs, Co-chair of the Student Affairs Committee, and Kathy Kendall-Tackett, Division Secretary.

Highlights from Executive Council Meeting

Judie then summarized the highlights from the Executive Council meeting the previous night.

- Anne DePrince, Chair of the Education and Training Committee, has produced a comprehensive listing of graduate training programs in trauma psychology. This list is available on our Division Web site.
- Elizabeth Carll, Chair of the International Committee, indicated that a project including the listing of international training programs will be compiled for 2008.
- Lenore Walker, Chair of the Nominations Committee, presented the names of officers who were recently elected.
  - ◊ Steve Gold, President-Elect
  - ◊ Beth Rom-Rymer, Treasurer-Elect
  - ◊ Charles Figley, Council Representative Elect
- Chris Courtois, Chair of the Practice Committee, is working on a CODAPAR grant, with Division 35, in order to collaborate on a project addressing violence against women and child maltreatment. They are developing resources for the Web on current best practices in trauma treatment.
- Steve Gold and Joan Cook, Co-Chairs of the Program Committee, put together the Division's first full convention program. They were able to collaborate with several other divisions, which has resulted in an increase in our overall program hours.
- Diane Elmore, Chair of the Public Policy Committee, reported on her committee. Her committee has been involved in addressing violence against women and addressing the mental health care needs of returning service personnel.
- Jennifer Freyd, Chair of the Science Committee, has also worked on several projects, including writing articles for the public that make the science of trauma available on a wider level.
- Desnee Hall, Chair of the Special Interest Groups (SIGs) Committee, reported that there are currently 17 proposed SIGs, three of which have completed the process to become official SIGs of the Division. The others are pending approval. Judie encouraged the membership to participate in Special Interest Groups.
- Topher Collier, Chair of the Publications Committee, announced that he is currently searching for an Associate Editor for All Committee Chairs are encouraged to write articles for this publication
- George Rhodes and Priscilla Dass-Brailsford, Co-Chairs of the Diversity Committee, reported that they are actively recruiting ethnic minority psychologists to the Division and have featured panels on minority issues on the 2007 program. The September issue of focuses on minority issues as well.
- Gil Reyes, Chair of the Disaster Relief Network, reported on the formation of the DRN, and identified the organizations that his committee has established relationships with. He indicated that they are currently identifying new members of this committee.
- Charles Figley, Chair of the Fellows Committee, indicated that all Division members who were Fellows in other Divisions were grandfathered as Fellows of Division 56. In addition, the Division added one new Fellow to its ranks this year.

• Emily Jacobs, Chair of the Student Affairs Committee, reported on her committee's efforts to recruit ethnic minority graduate students. This committee is also participating in the fundraiser, the book silent auction at the dessert social.

• Laura Brown, Web master of the Division Web site, reported on new additions to the Web site, and encouraged all committee chairs to submit photos and brief statements about why they became interested in trauma psychology.

• Harriette Kaley was recognized as the APA Division 56 Council Representative for this year.

Journal Working Group

At the Executive Council meeting, the president of Taylor & Francis and director of APA Publications presented their proposals for a Division 56 journal. The Journal Working Group is meeting further to consider the offers that these two publishers presented at the meeting. Judie asked Terry Keane and Melba Vasquez to join that working group. Both agreed.

Media & Publicity Committee

A new committee on Media & Publicity was approved at the meeting. Lenore Walker will chair this committee.

Summit on Violence and Abuse

Bob Geffner, Division President Elect, provided information about the Division's co-sponsorship of a summit on violence and abuse, which will take place on February 28-29 in Bethesda, in conjunction with the mid-winter meetings of several other divisions.

Treasurer's Report

Beth Rom-Rymer, Treasurer Elect, presented our revenues and expenditures. Dues are the primary source of our revenue. Ads for the newsletter are another important funding source. At mid-year, Division expenditures were $17,851. Printing and mailing the newsletter is one of our major expenditures, but an important one in that it helps recruit new members. The Division hospitality suite cost $1,725, but most of this amount was covered by donations. After expenditures, we currently have approximately $7,000.

Motions Passed at the Executive Council Meeting

Kathy Kendall-Tackett, Division Secretary, presented the motions that had been passed at the Executive Council meeting. These are summarized below. She then motioned that the bylaw changes approved by the Executive Council be accepted by the Division members in attendance. They were approved unanimously.

Division Awards

Terry Keane, member of the Awards Committee, presented certificates to outgoing officers and committee chairs: Melba Vasquez (Treasurer), Harriette Kaley (Council Representative), Steve Gold (Program Co-Chair), and Laura Barbanel (Member at Large).

Terry then presented the Division's awards for outstanding contributions. The recipients were as follows.

• Carolyn Allard, Dissertation Award

• Chris Courtois, Outstanding Contributions to Independent Practice

• Dean Kilpatrick, Outstanding Contributions to the Science of Trauma Psychology

• Judie Alpert, Outstanding Service Award

Judie adjourned the meeting at 4:55 p.m.

Respectfully submitted,
Kathy Kendall-Tackett

Summary of Motions Passed

2007 Budget

Motion: Move that the Council accept the mid-year budget for 2007

Nominations and Elections

Motion: Move to make the recommended bylaw change regarding nominations and elections

This Committee shall be chaired by the Past President, and include an individual appointed by the President, and an individual appointed by the President-Elect. It shall be responsible for soliciting nominations for elected offices in the Division, conducting elections in coordination with the Elections Office of the American Psychological Association, and preparing proposed changes to the Division's by-laws for vote as needed.

Special Interest Groups (SIGs)

Motion: Move that SIGs must include at least 10 members of Division 56

Motion: Move that the Council approve the rules and procedures that will enable the Division membership to create Special Interest Groups.

Motion: Move to make the following bylaw change regarding SIGs

There shall be a Council of the Division. Its membership shall consist of the following persons:

a. The elected Officers of the Division

b. Representative(s) to the APA Council of Representatives to be elected to a three-year term, renewable for 1 term

c. Three members at large, of whom one will be chosen for diversity from a slate of historically underrepresented members of the trauma field, to be elected to two-year staggered terms, renewable for two terms

d. The Student Representative, to be elected to a two-year term, renewable for one term

e. The Professional Affiliate Representative, to be elected to a two-year term, renewable, for one term

f. The Editor of the Division's Newsletter to be appointed by the Executive Committee to a three-year term, renewable for one term

g. The Editor of the Division's Journal, if applicable, for a three year term, renewable for two terms

h. Chairs of all Committees of the Division, for a one-year term, renewable if appointed by the incoming President of the Division

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i. Web Master, for a three-year term, renewable for two terms

j. Special Interest Group Coordinator, for a three-year term

Motion: Move that the Council endorse the list of proposed Special Interest Groups that has been compiled this year in response to member request.

Motion: Move that the Council confer Special Interest Group status to any SIGs that meet the requirements of the rules and procedures at the time of the Council meeting.

SIGs Approved:

a. Child and adolescent trauma

b. Dissociation

c. Trauma to postcolonial people

Publications

Motion: Move to approve Publications Policy

Awards

Motion: Move to create an Early-Career Award

BOOK REVIEWS

Wounded by Reality: Understanding and Treating Adult Onset Trauma

By Ghisliane Boulanger, Mahwah, NJ, 2007: The Analytic Press, 202 pages

Reviewed by Elizabeth Goren, PhD, New York University, Postdoctoral Program in Psychotherapy and Psychoanalysis

Wounded by Reality, as its provocative title suggests, inspires the reader to follow the author, Ghislaine Boulanger into the pain, horror and grief that is the emotional life of surviving "the extremes of experience" (p. 2). Ghislaine Boulanger begins with an overview of trauma literature and research and only gradually introduces the more disturbing clinical material, with the care and confidence that evokes her clinical method. This book raises important general points relevant to any psychologist, like the need for more rigorous and refined terminology, and looks at current knowledge about the psycho-biological effects of catastrophic trauma from a psychoanalytic perspective. Boulanger's main focus is the formulation of her own phenomenologically based psychoanalytic model for adult onset trauma, which any therapist who works with this population would find useful and compatible with their working model. Written with sensitivity, grace and honesty, the ideas, insights and suggestions clearly enough to be accessible to non-analytically oriented readers, clinicians from varying backgrounds and experience with trauma will find this book heartwarming and instructive.

Dr. Boulanger's major contribution is in addressing the challenge all therapists face, regardless of model, in working with the emotionally intense relationship with trauma survivors. Directly speaking from her own clinical experience, disclosing her own experience as a therapist working with this population, Boulanger sets forth a paradigm for managing and constructively utilizing the therapists' feelings, what is commonly referred to as counter-transference in psychoanalytic language. Several chapters are devoted to guiding therapists in finding the balance of full emotional involvement without undue risk of re-traumatizatizing the patient or traumatizing the therapist.

Stating that psychoanalysts possess "the tools but not the theory" (p. 3) for understanding catastrophic trauma, Boulanger takes the field to task for "overly inclusive definitions of trauma" (p. 12), for equating crisis with trauma, and for conflating childhood trauma with adult onset trauma. She writes about the historic "tumultuous" (p. 44) relationship of psychoanalysis to trauma, wherein "the very word trauma has been stretched so think in psychoanalytic circles as to have become almost meaningless" (p. 10). The mixing of terminology, like using trauma to refer to both the event and the psychological impact on the person, are criticisms which are relevant to other areas of trauma psychology and to the culture at large almost as much as they are certainly valid for the field of psychoanalysis. Insufficient rigor, Boulanger tells us, is an injustice to those who have actually survived truly traumatic life experience. For example, on 9/11, she writes, "We were terrified….. we were shocked; we were not traumatized. I reserve the term trauma for those were actually caught up in the terror at Ground Zero and thought they were in danger of losing their lives, for the families of those who were killed, and for the first responders" (p. 12).

Wounded by Reality is a major step toward correcting the "theoretical shortfall" (p. 4) in psychoanalytic trauma theory, particularly in distinguishing between adult and child onset trauma. Traumatic dissociation in children, according to Boulanger, creates splits in the still developing personality structure, and serves an adaptive function by blocking out painful memory and knowledge. In contrast, Boulanger argues that the dissociation and memory dysfunction which takes place after a trauma in the fully developed adult are highly maladaptive: "In adulthood, the dissociative process in the face of trauma does not create further splits in a developed personality but defends against terror leaving an indelible memory of the dissociative experience itself" (p. 27–28). With a fully matured capacity to comprehend mortality, adults in the face of catastrophe or other truly traumatic situations literally fear for their lives. It is the very ineffability and incomprehensible horror of real trauma that becomes the "unbridgeable gap at the heart of traumatic experience" (p. 55).

Faulting psychoanalysis for too often insistently locating the source of pathology in the person rather than in the situation, Boulanger's thesis and therapeutic model revolves around the

crucial idea, hence the title, that external reality is the source of the wound in adult onset trauma. Survivors and witnesses to life threatening events and the unimaginable violence find themselves in possession of the unbearable existential truth that manages to escape consciousness under normal circumstances, namely our fundamental vulnerability and mortality in the face of indifferent reality. With their intimate knowledge of death they feel set apart from and alienated from the world of shared illusion and denial of death that governs daily life. Following Boulanger's thinking, it seems that the phenomenological paradox of the survivor is that she has been robbed of the capacity for normal dissociation. Gripped in the awareness of life's fragility, bereft of the sense of self continuity, "time stands still" (p. 14) for the survivor, who becomes locked in the "mortal self first encountered during the catastrophe" (p. 69) where the external world reverberates with "the internal world of nightmares and terrifying fantasies." (p. 69)

My one point of departure from Boulanger's indictment of psychoanalysis is that the historic contribution of the American cultural and interpersonal school of psychoanalysis in introducing and stressing the role of actual events Boulanger refers to. The interpersonal school, which adheres to the principles of operationalism and pragmatism, emerged from mainstream psychoanalysis mid twentieth century as a rejection of the self-insulated model of mind that Boulanger critiques, and was founded on the central premise that real life events and environmental conditions define and continually shape an individual's behavioral, mental and emotional life. Though the early interpersonalists did not tackle trauma as a distinct subject like the Freudians, on whom Boulanger focuses her critique, real life events, past and present, at the individual, group and cultural level, including that which falls under the rubric of trauma, have always been central to the tenets of interpersonal theory and therapy (see Lionels, Fiscalini, Mann & Stern, 1995). Two of its main leaders, Harry Stack Sullivan and Erich Fromm, devoted enormous energy to working and writing about the nature of war and the impact of other catastrophic societal conditions on the human psyche in pre- and post- World War II.

The literature on which Boulanger relies, however, might lead the reader to think that the shift within psychoanalysis only began with Lacan's introduction of "the Real" and Steve Mitchell's spearheading of the contemporary relational model. Nonetheless, Boulanger's critique of "psychoanalysis conflating external events with internal experience" (p.56), her insistence on remaining experience near, and the way she sticks to the details of patient therapist interaction and each of their experiential struggles, place Ghislaine Boulanger squarely within the interpersonal tradition.

In the psychoanalytic literature, Wounded by Reality follows in the tradition of Grand's The Reproduction of Evil, in bringing an existential, phenomenological perspective to psychoanalytic theory and addressing the clinical complexities and therapeutic challenges restoring full sense of aliveness to the survivor. Written with the immediacy, and the visceral and sensory vividness that evokes the traumatic experience she describes, Boulanger's ideas are accessible to the non-analytic reader, and make Wounded by Reality stand out among the many books available on trauma as a primer for the novice therapist and much needed clinical text for the seasoned clinician. The clinical challenges of potential re-traumatization of the patient and secondary traumatization of the therapist, subjects that have received attention in the literature, are covered. Through detailed case material, Boulanger covers the therapeutic issues of preventing patient re-traumatization and secondary traumatization of the therapist. But the heart of her contribution lays in the way she describes and explains the nature of catastrophic dissociation, its impact on the individual, and its effect on others, in particular on the clinician. Eschewing reliance on schematic models, Boulanger describes the phenomenology of dissociation and develops a model for therapists to navigate through the emotional turmoil and defensive distancing that they experience in this work.

The survivor, having been robbed of his sense of agency, according to Boulanger, becomes "driven by sensation…. (in which) the rapid cycling of state-dependent traumatic memories, prompted by a sound, a smell, an affect, a visual cue, a sudden turning the weather, even a particular word" (p. 82). Bringing abstract concepts of self to life, she writes, "the body becomes the actual site in which memories that cannot be spoken, affects too powerful to be born, thoughts that cannot be thought and meanings too horrifying to contemplates are encrypted in apparently concrete symptoms," (p. 86) for "The body insists on witnessing what the mind cannot bear," (p. 87), inevitably leading to the characteristic numbness of trauma produced by unmanageable states of arousal.

Struggling to retain what Boulanger calls the strength of innocence outside the patient's grip in the horror of catastrophe, therapists often unconsciously resist full affective engagement with the patient, and can look for refuge in theory or in formulaic clinical notions, which risks further alienating the survivor. Here is where Boulanger offers a unique method for constructive therapeutic interaction that helps to transform the safe but "lifeless accounts" (p. 125) of survival into a narrative that restores life to the person and their story. She does this not by looking to the "authority of theory" (p. 155) but by utilizing her own experience. For instance, when a woman suddenly revealed her daughter's murder with flat blankness, Boulanger found herself "struck thoughtless" (p. 114). This pushed her to questions whether she had "the right to bring her out of her self imposed cold storage?" (p.106). It was only by breaking through her own dissociation and feelings of helplessness that Boulanger found that she was able to help the patient move from being a "mute observer to her own loss to become a witness to her own survival" (p.114). Boulanger shows us that a therapist's willingness to face his own vulnerability and meeting one's own mortal self in the patient's experience is what actually earns the patient's trust.

The last chapters of the book are chock full of case illustrations where Boulanger shows the creative use of narrative techniques. I leave it to the reader to buy this book to learn about her innovative methods. I look forward to the next volume of *Wounded by Reality*, in which I hope Boulanger will share how the trauma narrative transforms the lives of these survivors.

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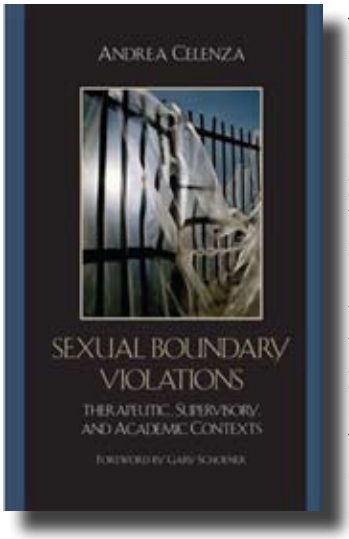
Sexual Boundary Violations: Therapeutic, Supervisory, and Academic Contexts

By Andrea Celenza

Reviewed by Dodi Goldman, PhD



"I have committed two crimes in my life," Freud is reported to have once remarked, "I called attention to cocaine and I introduced Stekel to psychoanalysis." Stekel, of course, was one of a handful of early analysts who drew from Freud's earliest musings the radical conclusion that psychoanalysis fosters sexual liberation. Whereas Freud labored honestly to process in his mind the inevitability of errant desire, some of his followers indulged in promiscuity as a self-evident good. There were even individuals for whom "curing through love" in the therapeutic setting became conflated with sex. What began as encouragement for one person to freely associate became permission for two people to associate freely. Perhaps because the therapeutic situation so readily immerses participants in erotic desire, it became necessary for psychoanalysis to develop a language that dampens sexuality. Words like "boundaries," "structures," "integration," and "containment" readily keep passion at bay. As does a word like "superego." The so-called "slippery slope" is, after all, the very terrain upon which psychoanalysis locates itself.

Andrea Celenza in her new book, *Sexual Boundary Violations: Therapeutic, Supervisory, and Academic Contexts*, takes a long hard look at the "slippery slope." And what she does quite admirably is shed light where there is often only heat. Celenza's primary purpose is "to identify pitfalls, vulnerabilities, stress points and warning signs for all mental health professionals, academics and clergy" (p. 15). The operative word here is "all." For one of Celenza's guiding assumptions is that we are misguided if we presume that perpetrators and victims are people fundamentally different than ourselves. "The inability or unwillingness to accept the now well-documented fact that we are all vulnerable to this type of transgression," she writes, "can stimulate a reactive anger…which blocks the capacity to come to terms with this vexing problem" (p. xxiii).

Celenza's work is based on a review of epidemiological studies, psychological evaluations, and her own experience with over seventy therapists, psychoanalysts, and clergy who have engaged in sexual boundary violations. Prevalence studies indicate an unacceptably high incidence rate (7–12%) between therapists and patients in the U.S. Psychiatrists, psychologists, and social workers have equivalent prevalence rates although there is a notably lower incidence among psychodynamically trained practitioners. The profile of the transgressor is remarkably consistent: he tends to be a middle-aged male in solo practice who engages with one female patient. Male practitioners account for over 80% of incidences. The female transgressors engage mostly with female patients. The victims of sexual boundary violations are, therefore, overwhelmingly female whether the therapist is male or female. The rates of male victimization at the hands of clergy, however, may be higher.

A crucial distinction needs to be drawn, argues Celenza, between one time offenders and psychopathic predators. The former are potentially amenable to rehabilitation, while the latter are not. Without sacrificing either moral compass or genuine compassion, Celenza enters the experiential world of the one time offender to examine both the precipitating circumstances and predisposing mental states. What she discovers is that seductions generally occur when vulnerable therapists find the therapy at an impasse. "In the most prevalent kind of sexual boundary violation," Celenza writes, "the seduction is most often the result of a defensive reaction to a difficult patient at a stressful time in the therapist's life" (p. 13). The simultaneously depriving and sexually overstimulating therapy situation, she concludes, replicates early childhood experiences of these therapists. Rather than tolerate and affectively process the myriad feelings arising during an impasse, the therapist becomes desperate and relies on sexualization to transform the way the patient is responding to him. The therapist, in other words, uses his sexuality to "ward off unconscious hostility towards the patient and wrest control of the process" (p.39). The seduction is designed to circumvent both the patient's and the therapist's hate and rage. Put differently: Celenza implies that a vulnerable therapist at a difficult phase in treatment is liable to desperately disavow any connection with an internalized bad object. By unwittingly escalating heroic measures to rescue, the therapist reenacts the very abuse his efforts were designed to cure.

Celenza tries to remain admirably empathic toward the transgressor's vulnerability without whitewashing his accountability. In so doing, she identifies potential precursors to sexual transgressions. Many therapists, she notes, console themselves that since they are educated, ethical, and well-intentioned it "could never happen to them." And since most transgressors are fully aware of the ethical codes, straightforward education is likely to play only a small part in what might help avert potential violations. It is far more efficacious, Celenza believes, for therapists to monitor the warning signs and vulnerabilities associated with such behavior and consult with their colleagues. The warning signs include: longstanding and narcissistic neediness or "lovesickness," covert rescue fantasies, intolerance of negative transference, a childhood history of emotional deprivation and sexual overstimulation (not to be confused with overt sexual abuse), a family history of covert and sanctioned boundary transgressions, unresolved anger toward authority, restricted awareness of fantasy,

and a tendency to transform countertransference hate to countertransference "love." This cluster of precursors is in no way predictive of therapist sexual misconduct. But there is strong evidence, Celenza suggests, that the motivation for sexual transgression most often involves "unconscious, denied, or compartmentalized conflicts about which the therapist had little insight" (p .29).

It has often been noted that sexual abuse is more about power than about sex. Celenza concurs. Indeed, questions of power play a central role in her understanding of both what constitutes and degrades the therapeutic space. Building on the work of Lew Aron (1996), Celenza notes how the therapeutic setup requires a constant negotiation of both the mutuality (a "we're in this together" type of experience) and asymmetric distribution of attention (a "you are in this alone" type of experience). Navigating this inherent tension is not easy for either party as there is a persistent press to unbalance, or level the hierarchy. "It can be said," Celenza writes, "that psychotherapy and psychoanalysis are processes by which the patient attempts to both empower and disempower the therapist (and vice versa) in an ongoing and increasingly more urgent way" (p. 58).

Celenza notes that the object of degradation in a particular boundary violation may be either direct or displaced. "Who," she asks, "is being degraded in this use of the couch as a fetish?" In the "direct perverse scenario," a narcissistically vulnerable therapist needs to control the dangerous subjectivity of the patient. Here, the patient directly constitutes the threat. Sexualization functions as a way for the transgressor to shift the process from one of enormous frustration and challenge to one of seduction and gratification. In the "displaced perverse scenario," on the other hand, the patient is a displacement object. The degradation is not primarily directed at her so much as toward the profession, the body or figure that oversees the dyad. The iconic couch, in this case, represents a third object, a symbol of analytic authority that is being unconsciously destroyed.

While sexual boundary violations in therapeutic settings constitute the core of this book, Celenza also brings her expertise to bear on supervisory, academic, and church settings. Prevalence studies reveal a higher incidence of sexual transgressions between educators/supervisors and students/supervisees than is found in studies of sexual misconduct between therapist and patient. And in the past 50 years, there have been 4,500 documented cases of sexual abuse by 1,100 Catholic priests, representing about 5% of the Catholic priesthood during that era. Celenza examines the way sexuality, power, a relationship with God, and elements of Christian doctrine intersect in the psychic experience of certain vulnerable individuals drawn to the clerical life. She places particular emphasis on "the absence of a father figure and/or the presence of a degraded father figure either in actuality or in the mind of the future priest's mother." Additional predisposing tendencies found among clergy include a "tendency toward concrete thinking", "extensive unresolved narcissistic needs," and "a great fear of and anxiety around the felt experience of anger and expression of aggression" (pp. 82–83).

Celenza provides prudent advice on strategies for treatment. She employs "composite" clinical examples to paint a picture of the inner world of transgressors and the clinical process of their rehabilitation. Her psychoanalytic orientation is keenly felt. The interpretive matrix informing her understanding can be roughly labeled "classical." Conceptualizations such as "unconscious split-off conflicts" and "libidinized aggressive fantasies that are acted out" abound. While there is much to be gained from this particular medium for understanding psychic life, it is worth noting that there are alternative lenses through which to view the material. Celenza notes, for example, that transgressors often report "being in a fog" (p. 37). She is also quite explicit that despite their full knowledge of ethical codes, they act with total disregard. The implication is that the therapist is in a state of simultaneously knowing and not knowing. At some point the transgressor cannot hold conflicting views of himself in relation to the victim within a single experiential state. Instead, a single intense non-reflective subjective truth ("This is alright, I'm doing it for her") takes hold. The transgressive act occurs, in other words, in a dissociated state of mind. Sequestered enactive memories decoupled from reflexivity may be as operative an element in boundary violations as the internal conflict suggested by Celenza.

Celenza is cognizant of the emotional currents that may impair an individual's capacity to manage the conflicted loyalties aroused once a therapist becomes aware of a colleague's possible transgression. And she considers the institutional blocks that serve to hamper judicious handling of reported abuse. She challenges us to cultivate ethical standards and diminish moralism. Her highly informative and comprehensive overview readily reminds us that we risk inflicting horrific damage when we fail to hold in mind the limits of our "love."

David Letterman's Top Ten

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Dissociation, Child and Adolescent Trauma, and Trauma to Post-colonial Peoples. While a committee has not yet been formed, we have a number of people who have expressed interest in a SIG focusing on Adult Survivors of Abuse. Desnee Hall has done an extraordinary job getting these SIGS off the ground. And we will have more soon!

Number Nine: Much Interdivisional Activity

Division 56 has been instrumental in the organizing of the American Psychological Association's (APA) Summit on Violence and Abuse in Relationships; Connecting Agendas and Forging New Directions. The Summit will take place in February 28–29, 2008, in Bethesda, MD. It is a combined effort of many groups, including sixteen divisions within APA. Division 56 plays a leading role here, and without Bob Geffner's

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David Letterman's Top Ten

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persistence and highly developed networking skills, I don't think this event would have been realized.

Also, Division 56 has been working with other divisions in a number of ways, including involvement in CODAPAR grants.

Number Ten: Forthcoming Division Journal

We are starting a division journal. It will be published by the APA. We will own the journal and, at the moment, it appears that members will pay very little for a subscription. At the time of this writing, the contract details are still being worked on. Laura Brown and her committee did a stupendous job in making this happen. Members of the executive board have been reading contract drafts and providing important input. For sure, we will have a division journal soon.

As I complete the list of the "Top Ten," I realize that it should be a list of the "Top Twenty." The Executive Committee has done a great deal of good work. I will briefly list a few more highlights, but please know that I am leaving out many more that should be included. Kathy Kendall-Tackett made sure that our work was represented in the newsletter that is sent to all divisions. Kathy, as the division secretary, performed many necessary tasks and she did these most graciously. For this we are all grateful. Melba Vasquez, our Treasurer, continued to receive awards throughout all of APA; somehow, despite all this activity, she was able to monitor our monies most carefully. Harriette Kaley served as our first and unofficial APA Council Representative. From reading her reports one would have thought we had actually attended the meeting. Charles Figley has just begun service in this capacity. Toby Kleinman, a lawyer, is our Professional Affiliate Representative. Legal eyes are often needed and she willingly contributes. Gil Reyes has been an active star as well on our EC Board. Diversity and Multi-Cultural Concerns Committee Chairs George Rhoades and Priscilla Dass-Railsford have been actively involved in keeping diversity issues in the forefront. Our Student Affairs Committee (co-chaired by Emily Jacobs and Kathy Dale) got us rolling: they established three important subcommittees (website, membership and publications) and have been helpful in countless ways. Patrick Meade has already begun assuming responsibilities as the incoming Co-Chair. I am amazed that we have not driven our first listserv manager insane. We thank Preetika Pandey Mukherjee for working with us to get the kinks ironed out. As chair of the Education and Training Committee, Anne de Prince and her committee put together a list of programs that offer training in trauma; this list is a wonderful addition for all of us. We now have what APA calls both "old" and "new" fellows, thanks to Charles Figley, our Fellows Committee Chair. Elizabeth Carll not only helped raise money for the newsletter but she also chaired our International Concerns Committee. Lenore Walker chaired our Nominations and Elections Committee, which put together a winning slate. Diane Elmore continues to do important work as Chair of our Policy Committee. I must give special thanks to Terry Keane. His wisdom, availability, when needed, and good cheer added enormously to the stature, presence and good feeling within the Division.

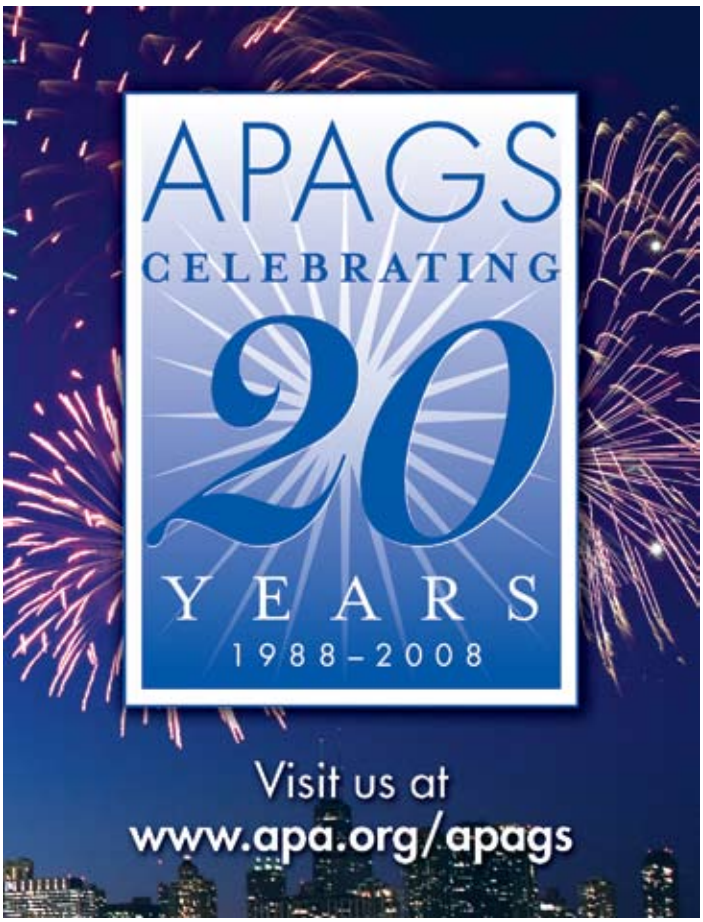
I could go on and on. Please don't be offended if I excluded mentioning you. There were just so many people who contributed so much to make this division happen and to make it fly. Also, I ask forgiveness for not listing names of committee members. While the contributions of committee members were enormously appreciated, a litany of names can make for dull reading. I trust that the committee chairs will acknowledge their hard work at a later time. I simply cannot give thanks enough to the very active and committed Executive Board of Division 56.

Lastly, I thank the membership for joining Division 56, for supporting the Division, and for participating in Special Interest Groups and other committees. Please know that I appreciate the hard work that is being done by all our members of behalf of trauma.

I am leaving the Division in very good hands. Bob Geffner took office as President of Division 56 on January 1, 2008. Prior to his taking office, he was a very active President-Elect and had already done much work in preparation for his presidency. The transition will be smooth. Steve Gold will follow Bob as President. Without question, we have two very devoted and hard-working guys at the helm for the next two years.

I do not like to say good-bye. Terminations have always been hard for me. In this instance, I am fortunate (I guess) because, as past-president, I must fill Lenore Walker's shoes as Chair of the Nominations and Elections Committee. The openings are for president-elect, member-at-large, and professional affiliate representative. Please let me know if you have interest in running for these positions.

That's it folks. I'll see you all around the "Division 56 Campus."



Welcome to 2008!

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follow up activities, including a think tank and presentations at the *13th Annual International Conference on Violence, Abuse and Trauma* in September in San Diego (see announcement on Page 37). As I mentioned in my previous column, the Summit is the first of many events during the next few years to focus on these issues, and members of our Division will have a major role in the planning. There will also be a mini-convention at APA this year that focuses on this topic, and Steve Gold is helping to coordinate it for us. I am very happy that Joan Cook and Richard Thompson have been co-chairing the Division 56 program this year at APA. It should be an exciting assortment of presentations and poster sessions. Some of these will be coordinated with other divisions as well. For the first time, we are trying to establish a hospitality suite program. I am also pleased to let you know that our Dessert Reception at APA, in conjunction with the Divisions for Social Justice and the Public Interest Directorate, which was very popular last year, will be sponsored this year by Taylor & Francis Publishers. We will be able to keep the tradition going, which is more good news! The silent auction of books should occur again as well.

Goals for 2008

We enter 2008 with nearly 1,200 members! This is quite an accomplishment at just the beginning of our second year. However, we cannot relax on such success. It is important that we all continue to let our colleagues know that there is a new home for those who work in or are interested in the trauma field. Our Division is open to psychologists in APA, those who may not belong to APA, and to professionals in other disciplines as affiliate members whether or not they are APA members. We also encourage students to join. Please copy the membership flyer (on Page 38) to give out at meetings and to colleagues. If we each can recruit just one new member, we will have over 2,000 in the division by the end of this year, which is our goal.

I mentioned in the last newsletter many of the goals for this coming year, including a second Council of Representatives position, an increased financial reserve, an expanded list serve, an increase in membership of early career psychologists, people of color and those from diverse backgrounds, additional students, and an increase in convention program hours for next year. It is also hoped that the Division will have its own Trauma Psychology journal officially approved and initiated this year so that publication can begin for 2009. This is likely to only add $20 to the dues, but a quarterly journal would then be included. We will have more details after our first official mid-winter board meeting the first of March, immediately following the APA Summit in Bethesda.

Task Forces and Substantive Issues

We established a few task forces in 2007 that will continue in 2008. All deal with very important, timely, and controversial areas. The task force for *Monitoring and Providing Feedback Concerning Trauma in DSM-V*, chaired by Terry Keane, will be continuing this year. It is anticipated that this task force will also continue in 2009. The task force on *Coercive Interrogations and Torture,* chaired by Nnamdi Pole, is also continuing this year. These issues have been the most controversial for APA in recent years, and have created a sad wedge for many in and outside of APA. Some of the issues will likely be presented at the APA convention this year too. *Trauma in the Military and Their Families* is new; it is chaired by Jaine Darwin, and will include issues of diagnosis and misdiagnosis as well as treatment for family members and returning veterans. A new task force is being established this year that will focus on the *Ethical Role of Psychologists in Dealing with Trauma and Abuse in Forensic Settings*. A chair has not been named yet.

As I mentioned previously, the two substantive issues that will be the focus this year are *The Traumatic Effects of Violence and Abuse in Relationships*, and *The Ethical Issues of Dealing with Trauma and Abuse in Forensic Settings*. The latter situation has been occurring for nearly two decades now, since trauma and abuse issues began showing up in various criminal, civil, and family law courts in the United States and in other countries. This inter-relationship and overlap of trauma and forensic psychology has taken on more importance in recent years as more mental health professionals conduct various types of forensic evaluations, act as expert witnesses, treat victims or perpetrators of violence and abuse, or testify about pertinent issues or research in this field. The most common types of cases involve intimate partner violence or violence in general, child maltreatment, elder abuse, child custody, PTSD, and levels of trauma with respect to civil damages or as mitigating factors in criminal courts. It has amazed me how frequently psychologists and other mental health professionals conduct evaluations of those who have been traumatized, been accused of being an offender, and/or testify in court as expert witnesses about issues related to such situations, even though they have an obvious lack of appropriate expertise or experience in the areas of trauma psychology, violence, and abuse. I will discuss these issues in more depth in a future column, and at the convention. However, it is incumbent on all of us in the trauma field to ensure that psychologists who provide information or testify concerning some aspect of trauma are adequately trained. It seems at times that "junk science" (i.e., information purported to be based upon research, scientific evidence, or accepted practice, but which is actually none of the preceding), is showing up in court rooms more frequently in cases involving some type of trauma. In many of these cases, a "battle of the experts" occurs (if both parties have the financial resources to hire experts), and judges, juries, and attorneys often can't separate the science from the junk and therefore discard both, or perhaps pay more attention to the person who comes across as more likeable even if the information is not valid. Unfortunately, it seems that we have not done an adequate job of policing ourselves ethically. One of the goals of the new task force mentioned above will be to review the ethical codes and their enforcement to determine whether recommendations are needed in this regard.

I look forward to an exciting year for the Division, and to meet many of you at one or more of our events this year. Please feel free to contact me (bgeffner@pacbell.net) if you have questions or concerns, or to give me ideas or suggestions for accomplishing our ambitious goals for 2008.

Take care and be safe!

Division 56 Council Meeting Minutes

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noted that people are joining the Division specifically because they were interested in being members of SIGs. Sandra will list current SIGs on membership materials and Laura will add a new page to the Web site.

Desnee asked that the Council adopt the rules and procedures on SIGs. Currently, a SIG requires at least 10 Division 56 members. A question was raised about whether they also needed to be APA members. After some discussion, Laura Brown moved that SIGs require only 10 Division 56 members; they did not also need to be APA members. This motion was approved.

Desnee moved that we accept the wording of the rules and procedures of SIGs, already approved by APA. This motion also passed unanimously.

Motion: Move that SIGs must include at least 10 members of Division 56

Motion: Move that the Council approve the rules and procedures that will enable the Division membership to create Special Interest Groups.

Motion: Bylaw change: Move that there be a change to the bylaws adding SIG Coordinator to the list of Council of the Division.

There shall be a Council of the Division. Its membership shall consist of the following persons:

a. The elected Officers of the Division

b. Representative(s) to the APA Council of Representatives to be elected to a three-year term, renewable for 1 term

c. Three members at large, of whom one will be chosen for diversity from a slate of historically underrepresented members of the trauma field, to be elected to two-year staggered terms, renewable for two terms

d. The Student Representative, to be elected to a two-year term, renewable for one term

e. The Professional Affiliate Representative, to be elected to a two-year term, renewable, for one term

f. The Editor of the Division's Newsletter to be appointed by the Executive Committee to a three-year term, renewable for one term

g. The Editor of the Division's Journal, if applicable, for a three year term, renewable for two terms

h. Chairs of all Committees of the Division, for a one year term, renewable if appointed by the incoming President of the Division

i. Web Master, for a three year term, renewable for two terms

j. Special Interest Group Coordinator, for a three-year term

Motion: Move that the Council endorse the list of proposed Special Interest Groups that has been compiled this year in response to member request.

Motion: Move that the Council confer Special Interest Group status to any SIGs that meet the requirements of the rules and procedures at the time of the Council meeting.

SIGs Approved:

- Child and adolescent trauma
- Dissociation
- Trauma to postcolonial people

Visitors from APA Directorates

Bob Walsh, from the APA Education Directorate, described the programs they offered and ways that Division members could get involved. They approve sponsors of APA Continuing Education programs. CE programs can be from our Division or with individual Division members. As a Directorate, they would like to do more distance learning, online training, and Web conferencing. These are other ways that Division members can teach others about trauma. Anne DePrince will be the primary contact between Division 56 and the Education Directorate. Anne will also attend the Education Directorate breakfast.

Luana Bossolo and Margie Schroeder, from the APA Practice Directorate, described some of what their program entails and how they can work with the Division. For example, the Practice Directorate oversees the APA Disaster Relief Network, and is a primary partner with the American Red Cross. They meet with providers who are going to disaster sites, and collaborate with the Board for Professional Affairs to support psychologists coming back from disasters. After Hurricane Katrina, they were able to give feedback to the Red Cross. The Practice Directorate also writes articles for the *Monitor* on "smaller" disasters (e.g., Virginia Tech, bridge collapses, mine episodes). They are always looking for more psychologists who want to be part of the Disaster Relief Network. There was also some discussion about whether DRN members should also be required to be members of Division 56.

The Practice Directorate also provides guidelines for psychologists doing research in disaster areas. This might be an area where the Practice Directorate can collaborate with our Disaster Relief Committee and a SIG on Disaster Relief.

Another way we can collaborate with the Practice Directorate is to help them review materials on disaster relief for the Web, the general public, and for the media. Materials APA produces end up not only on the APA Web site, but also on other sites. They would like to be able to tap into our expertise. Terry noted that the National Center on PTSD also has a strong Web site, with lots of information on disaster. Perhaps we can link with that site.

Our next guests, Heather Kelly and Karen Studwell, from the Science Directorate, described the current work of the Science Directorate and how it overlaps with the interests and expertise of the trauma division. Some of their research interests include child abuse and neglect, family violence, and interpersonal violence. They are collaborating on a project with the National Child Health and Human Development office. And they want to establish a link with psychologists working within the VA system who are helping meet the needs of returning soldiers. They are assembling teams to testify to Congress and congressional staffers about these needs and would like to collaborate with us in this work.

Division Journal

At this point in the meeting, we were joined by Gary VandenBos, chairman of APA Publications, and Kevin Bradley, president of Taylor & Francis.

Shortly before the APA Convention, our Council learned

that Taylor and Francis had purchased Haworth Press. This was highly relevant to the discussion of our Division journal because our journal committee had decided to have APA purchase the existing Haworth journal, *Journal of Psychological Trauma.* Haworth had been willing to sell this journal, and APA had been willing to buy it. However, Taylor & Francis, as the new owners of the journal, were not willing to sell it. The Executive Council identified three possible courses of action.

1. Send the journal committee back to the drawing board to draft new recommendations.

2. Ignore recommendations and go with *Journal of Psychological Trauma,* now a Taylor & Francis journal.

3. Go with the journal committee's recommendation to go with APA and start a journal from inception—including assembling the editorial board.

Judie indicated that she, Bob and Steve (current editor of *JPT* and president-elect) met before our meeting and developed a list of features that they would like in the journal. Judie asked both Gary and Kevin to respond.

Question	APA Response	Taylor & Francis (T & F) Response
Would the Division receive 10–15% of the gross sales?	Yes.	Most likely not a problem, but will double check. There is a fixed amount of money for the editor and for the division.
Will the journal be marketed directly to APA members?	Yes. It will also be marketed internationally.	Yes. Typically, T & F has a large international presence. They will also promote it within the association.
Will the Associate Editor and Full Editor each receive $2,000 each?	Yes.	Yes. There's a budget for fixed costs.
Do you have an electronic back office in place? Is there online copyediting?	Yes. There is electronic submission and release of articles.	Yes.
Can we have a 5-year contract?	Yes.	Yes.
Is there $1,500/ year available for a graduate assistant for style editing?	Yes. But there is no need for an onsite assistant. This process is all electronic.	Yes.
Who owns the copyright to the journal?	Division 56 owns the copyright and APA would administer it.	Taylor and Francis would own it.
Will the Division be able to control the content of our journal?	Yes.	Yes.

Following this overview, Council members made comments and posed additional questions. Jennifer brought up the issue of open access. Authors need to be able to share what they write with others in the field, and journals that won't allow authors to share pdfs of their work or post it on their own Web sites, will find that younger investigators do not want to write for them. Although open access may cut into profits, quality is, in the long-term, more important. Kevin replied that open access was not feasible in that it would substantially diminish profits—for us, and the publisher. Quality is important, and we can have that without giving away our profits. Gary replied that APA would offer younger investigators more options for accessibility of their work. While not complete open access, APA offers more access to electronic versions of articles, which increases access both in the U.S. and internationally.

After Gary and Kevin left the meeting, the group discssed their offers in more detail. Judie suggested that both Melba and Terry be added to the journal committee. Both agreed. The question they were being asked to consider was whether we should pursue publishing with one of these two publishers, or should we pursue other offers. Judie asked Laura to draft a letter to both Kevin and Gary clarifying offers made during our meeting. Laura will give a report by the mid-winter meeting. If any Council members have comments before then, please forward them directly to Laura.

DSM V Committee

Judie, along with Bob Geffner, appointed a task force to address the upcoming revision of the DSM that will provide input on trauma-related diagnoses in *DSM-V*. Dan Brown will chair this task force. Chris and Lenore led the discussion on this topic at the meeting as Dan was unable to attend. *DSM V is* due 2012, with a draft circulated in 2009 for comments. Judie indicated that the Division and the American Psychological Association needs to be involved in this process, especially since no trauma-focused committees have been formed.

2007 Budget

Melba presented the 2007 budget for approval. She clarified that $14,000 in the budget was the difference between publishing an electronic vs. paper version of the newsletter. She moved that we accept the current budget.

Motion: Move that the Council accept the mid-year budget for 2007. This was passed unanimously.

A draft of the 2008 budget was accidentally left out of the agenda packet. Kathy will send this to all Council members and

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members will approve the 2008 budget via email.

The next budget item was whether we had sufficient resources to fund people to attend the mid-winter meeting. At the 2007 mid-winter meeting, the Council agreed that we would meet in person if at all possible. We voted and chose to have a conference call rather than a face-to-face mid-winter meeting. Bob pointed out that the Division is a key sponsor of the Violence Summit that will be conducted in collaboration with other APA Divisions' Mid-Winter meetings, and we need to be there. If at all possible, Council members should plan to be there.

In addition to the budget, Melba opened an opportunity to brainstorm about other funding options. She also presented some ideas from the finance committee. These included mid-year conferences, the Division journal, expanded contributions for the convention, and expanded ad revenue for the newsletter.

The Finance Committee is currently seeking new members.

Committee Reports

Nomination & Elections

Lenore requested that the Council approve a change to the bylaws regarding elections. The motion passed unanimously.

Motion: Move to accept the recommended bylaw change regarding nominations and elections.

This Council shall be chaired by the Past President, and include an individual appointed by the President, and an individual appointed by the President-Elect. It shall be responsible for soliciting nominations for elected offices in the Division, *preparing a slate and establishing procedures to stand for election to open positions,* conducting elections in coordination with the Elections Office of the American Psychological Association, and preparing proposed changes to the Division's by-laws for vote as needed.

Bob raised the issue of what to do in the event that there is a vacancy on the Council. Currently, we would need to have an election with the entire membership. Can we change that to allow for a presidential appointment to fill the remainder of a term? This may not require a bylaw change. We'll discuss this issue further at our next meeting.

Communications: Newsletter

Topher thanked the Council for their excellent contributions to the newsletter, and he encouraged the group to keep the articles coming. He also asked committee heads for future articles. It is important to let the membership know about all the hard work that the committees are doing. This is also a great way to recruit future committee members. The Council suggested several other ideas for newsletter articles.

- Ask conference presenters on the trauma program to write a one-two paragraph description of their presentation.
- Have students interview board members on their work and why they got into the field.
- Have Council members interview students about their work and their interest in trauma for a student column.
- Have publishers place ads in the newsletters for upcoming books on trauma.
- Place an ad in the newsletter soliciting candidates who are interested in being an Associate Editor.

Topher indicated that $2,200 was raised from advertising revenue for the Newsletter.

Topher made a motion that the Council accept the Publications Policy included with the agenda packet. The motion was approved unanimously.

Publications

Motion: Move to approve Publications Policy.

Communications: Web Site

Laura Brown informed the group that the Division Web site is getting a lot of hits each month. She suggested that we exchange links with the Web sites from ISTSS, ISTSD, and NCPTSD, with her criteria being that we exchange links with organizations that are larger than Division 56. She also suggested that we offer Division 56 merchandise for sale on our site.

Laura asked that Council members who have not sent her a photo or a brief summary about why they became involved with trauma psychology, to do so soon so they can be added to the site. This portion of our site gets a lot of hits, so it's helpful if it is as up-to-date as possible.

Communications: Listserv

Judie raised the issue of our Division listserv. There has been some concern about the volume of email that members are receiving, especially on the EC listserv. Also, there were some complaints from Division members who were added to the Division listserv without their permission. Another question is how we can get the other 1,000 Division members to sign up for our Division listserv so that we can communicate with them from time to time.

Bob said that one way we can reduce the number of emails people receive from the listserv is to ask Keith Cooke to change the setting so that when people hit reply, it will only go to the person who sent the originally sent the email. This will reduce volume considerably.

As for participation by the broader membership, one possibility is that we have a list that is announcements only. That way, when there are important things to share, we have a way to contact everyone. Another way to include the membership, without offending anyone, is to send a link to members and ask them to sign up for the listserv. That way, we are not adding them without their permission.

Judie thanked our current listserv manager, Preetika, for all her hard work on our behalf.

Public Policy Office

Diane Elmore, speaking on behalf of the APA Public Policy Office, told the group of several current projects the Public Policy Office is involved in that are directly relevant to trauma. Some examples are the Violence against Women Act (VAWA) and various mental health initiatives aimed at meeting the needs of returning veterans. Terry commended the work of the Public Policy Committee in general, and Diane's work in particular, pointing out that she has been a real asset to APA and to trauma

psychology. Diane indicated that their office would like to involve Division members in their work.

On a related topic, one way Division members can participate is through contact with the media. Lenore suggested that we start a Media Committee so that we can quickly coordinate a response.

Liaisons Committee

Joy was unable to attend the Council meeting. She did send a list of individuals and associated organizations that we might want to connect with. Judie asked the group to review the list. Some of Joy's suggestions for possible contacts are as follows.

- ISTSS, Kathy Steele
- ISSTD, George Rhodes
- Child maltreatment section (APA, Division 37, Section 1), Sharon Portwood
- APSAC, Tony Mannarino
- IVAT, Bob Geffner will be liaison for this
- Leadership Council on Child Abuse & Interpersonal Violence, Joy will be liaison for this
- American Psychiatric Association, Paul Fink will do this
- American Academy of Pediatrics, need a recommendation
- National Association of Social Workers, Fran Waters will do this
- American Nursing Association, need a recommendation
- American Medical Association, need a recommendation)

Membership Committee

Sandra reported on the current status of our membership. We currently have almost 1200 members, which, for a new division, is a very high number. We've also had 103 members resign, some in protest over APA's stand on interrogation and torture.

Sandra also needs people on her committee. She is currently the only member of this committee and could use some help. She will also announce the need for committee members at the business meeting.

Student Affairs Committee

Emily updated the group on the status of the silent auction, which took place the following day at the dessert reception. She also announced that Patrick Meade is the new co-chair of her committee. As for recruitment of new student members, Emily indicated that the most effective recruitment often comes from efforts of full members to recruit their students.

International Committee

Elizabeth Carll, Chair of the International Committee, submitted a report indicating that an international focused program was organized for the 2007 APA Annual Convention on psychological trauma with presentations covering large-scale to individual intervention. The symposium included 4 international participants, as well as participants from the U.S. The symposium was cosponsored by Divisions 55 and 42.

For 2008, the Committee will develop a resource listing of international trauma training programs. This will serve as a resource for members and other visitors who are interested in international trauma issues. The information will be posted the International Committee page on the Div 56 website.

Diversity Committee

George reported that the Diversity Committee has made several important strides. There were two special sessions on diversity issues on the convention program. Ethnic-minority issues are also the focus of the next issue of *Trauma Psychology*. The Committee wants to provide advanced training on cultural differences and trauma. They also want to work with ethnic-minority students and provide opportunities for internships.

Education Committee

Anne provided the group a comprehensive list of graduate programs with trauma training. She also reported on collaboration with the Education Directorate.

Awards Committee

Terry reported on the first recipients of Division awards. They are as follows.

- Dissertation Award: Caroline Allard
- Outstanding Contribution to Practice: Chris Courtois
- Outstanding Contribution to Science: Dean Kilpatrick
- Outstanding Service: Judie Alpert

He also made a motion that we add an Early Career Award next year. There was some discussion about whether this award should be for research or practice, and the group decided it could be for both; and that we needed to continue avoiding a scientist/practitioner dichotomy. The motion passed unanimously.

Motion: Move to create an Early-Career Award

Disaster Relief Committee

Gil reported briefly on the activities of the Disaster Relief Committee. They are preparing a manual on how to respond to disasters. They are also building connections with agencies involved in disaster relief, including the Red Cross and APA.

After this final report, Judie commended the group on how far we have come and how much we have accomplished in the Division's first year. With that, the meeting was adjourned.

Respectfully submitted,
Kathy Kendall-Tackett
Secretary, Division 56

Summary of Motions Passed

2007 Budget

Motion: Move that the Council accept the mid-year budget for 2007

Motion: Move to make the recommended bylaw change regarding nominations and elections

Nominations and Elections

This Committee shall be chaired by the Past President, and include an individual appointed by the President, and an individual appointed by the President-Elect. It shall be responsible for soliciting nominations for elected offices in the

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Division, *preparing a slate and establishing procedures to stand for election to open positions,* conducting elections in coordination with the Elections Office of the American Psychological Association, and preparing proposed changes to the Division's by-laws for vote as needed.

Special Interest Groups (SIGs)

Motion: Move that SIGs must include at least 10 members of Division 56

Motion: Move that the Council approve the rules and procedures that will enable the Division membership to create Special Interest Groups.

Motion: Move to make the following bylaw change regarding SIGs

There shall be a Council of the Division. Its membership shall consist of the following persons:

a. The elected Officers of the Division

b. Representative(s) to the APA Council of Representatives to be elected to a three-year term, renewable for 1 term

c. Three members at large, of whom one will be chosen for diversity from a slate of historically underrepresented members of the trauma field, to be elected to two-year staggered terms, renewable for two terms

d. The Student Representative, to be elected to a two-year term, renewable for one term

e. The Professional Affiliate Representative, to be elected to a two-year term, renewable, for one term

f. The Editor of the Division's Newsletter to be appointed by the Executive Committee to a three-year term, renewable for one term

g. The Editor of the Division's Journal, if applicable, for a three year term, renewable for two terms

h. Chairs of all Committees of the Division, for a one year term, renewable if appointed by the incoming President of the Division

i. Web Master, for a three year term, renewable for two terms

j. Special Interest Group Coordinator, for a three-year term

Motion: Move that the Council endorse the list of proposed Special Interest Groups that has been compiled this year in response to member request.

Motion: Move that the Council confer Special Interest Group status to any SIGs that meet the requirements of the rules and procedures at the time of the Council meeting.

SIGs Approved:

- Child and adolescent trauma
- Dissociation
- Trauma to postcolonial people

Publications

Motion: Move to approve Publications Policy

Awards

Motion: Move to create an Early-Career Award

Graduate Student Scholarships to Be Offered for Teaching the Psychology of Men Continuing Education Program at the 2008 APA Convention

Teaching the Pyschology of Men will be a Continuing Education Program during the APA Convention in Boston. Eight or more scholarships will be awarded to graduate students who want to attend the workshop free of charge. Issues related to the psychology of men and masculinity are increasingly identified as important areas in psychology including boy's and men's development across the life-span, issues of multiculturalism and sexual orientation, violence against women, homophobia, fathering, men's health and others. Therefore, the teaching of the psychology of men is central to psychology, yet one of the least developed areas in psychology.

The purpose of this introductory workshop will be to assist psychologists in developing course work on the psychology of men using the theoretical and empirical literature on men and masculinity. Participants will learn basic knowledge on how to create a psychology of men course or how to infuse this content into existing courses on gender or the psychology of women. Each presenter will share their syllabi, reading materials, class manuals, evaluation processes, and other resources. The workshop will discuss pedagogical processes such as traditional lecturing, psychoeducational techniques, group discussion approaches, use of video media, student assessment techniques, managing classroom problems, and the infusion of diversity and multiculturalism as critical content.

The goals of the workshop are to help psychologists: 1) Design a psychology of men course or incorporate the psychology of men into existing courses; 2) Locate syllabi, core concepts, readings, media, self assessments, and other resources to teach the psychology of men; 3) Utilize multiple teaching methods when teaching the psychology of men including psychoeducational and multicultural approaches; and 4) Enumerate the critical problems/dilemmas and solutions when teaching the psychology of men.

The teaching faculty of the workshop include: Jim O'Neil, PhD, University of Connecticut, Storrs, CT; Michael Addis, PhD, Clark University, Worcester, MA; and Jim Mahalik, Boston College, Chestnut Hill, MA.

Information about the graduate student scholarships, how to apply, criteria for selection, and the deadline date can be obtained by emailing Jim O'Neil, Chair, Committee on Teaching the Psychology of Men, Division 51 of APA, at: jimoneil1@aol.com.

Registration For APA Continuing Education Programs Begins May 1, 2008: Call 1-800-374-2721, ext. 5991; Online Registration at apa.org/ce

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- Promoting policy development
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- Continuing Education credits

AREAS OF EMPHASIS

- At Risk Youth
- Child Maltreatment: Child Victims and Adult Survivors
- Children Exposed to Violence
- Healthcare Issues
- Intimate Partner Violence: Victims and Offenders
- Legal and Criminal Justice Issues
- Sexual Assault: Victims and Offenders
- Trauma (including in the Military and Their Families), and more!

WHO SHOULD ATTEND?

- Advocates
- Researchers
- Psychologists
- Social Workers
- Nurses
- Judges
- Attorneys
- Clergy
- Counselors
- Marriage and Family Therapists
- Volunteers
- Physicians
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Mission of Division 56
Trauma Psychology

The Division of Trauma Psychology of the American Psychological Association (APA) provides a forum for scientific research, professional and public education, and the exchange of collegial support for professional activities related to traumatic stress. Our goal is to further the development of the field of psychological study of trauma and disaster in its scientific, professional, educational, and public policy aspects. The Division also helps to advance scientific inquiry, training, and professional practice in the area of trauma treatment and research as a means of furthering human welfare.

We welcome all psychologists and other individuals in the mental health and other fields who have an interest in trauma psychology.

Services to APA and its Membership

Training: Training, developing knowledge and sharing of expertise in the area of traumatic stress exposure and PTSD.

Health Service Delivery and Research: Work toward improving culturally sensitive service delivery in mental and physical health for people with trauma exposure; development of an integrative journal for the field in an effort to further a more practice-informed approach to trauma research and a more scientifically-informed approach to trauma practice; opportunity for scientist-practitioners, practitioners, and scientists to work together to develop knowledge about trauma.

Consideration and Integration: Consideration and integration of diverse areas of study such as: combat, rape, domestic violence, child physical and sexual abuse, refugee, torture survivors, prisoners of war, community violence and occupational traumatic stress; exploration of underlying principles leading to the development of psychopathology, disability and distress, resilience, and mental and physical health; integration of clinical knowledge and research.

Academic Support: Support for academic researchers studying these diverse areas, possible development of an integrative journal for the field in an effort to further a more practice-informed approach to trauma research and a more scientifically-informed approach to trauma practice.

Funding: Work in conjunction with federally-funded centers of excellence to support clinicians, researchers and students in the field.

Prevention: Develop and support prevention research and practice.

Public Education: Projects working towards public education.

Publications: Producing materials on a wide range of trauma-related topics.

Membership Benefits

- Members keep up-to-date on the latest developments in trauma psychology
- Members also get 30 % discounts on journals in the field of trauma
- A Trauma newsletter
- Participation in the Division's annual meetings
- Voting privileges to elect representatives

Yes, I want to join Division 56!
MEMBERSHIP APPLICATION

APA Membership Status

☐ Member	$25	☐ Professional Affiliate	$25
☐ Fellow	$25	☐ Student Affiliate	$10
☐ Associate	$25		

NAME (please print)

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Membership $_____

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JOURNALS

Journal of Psychological Trauma (Formerly Journal of Trauma Practice)

Journal of Trauma & Dissociation

Journal of Aggression Maltreatment and Trauma (2 volumes annually)

Journal of Child Sexual Abuse

Journal of Emotional Abuse

Please register online at www.apa.org/divisions/div56/membership.html or download our brochure at www.traumapsychology.org. You can also fax this application to (925) 969-3401 or mail the completed application with your payment to:

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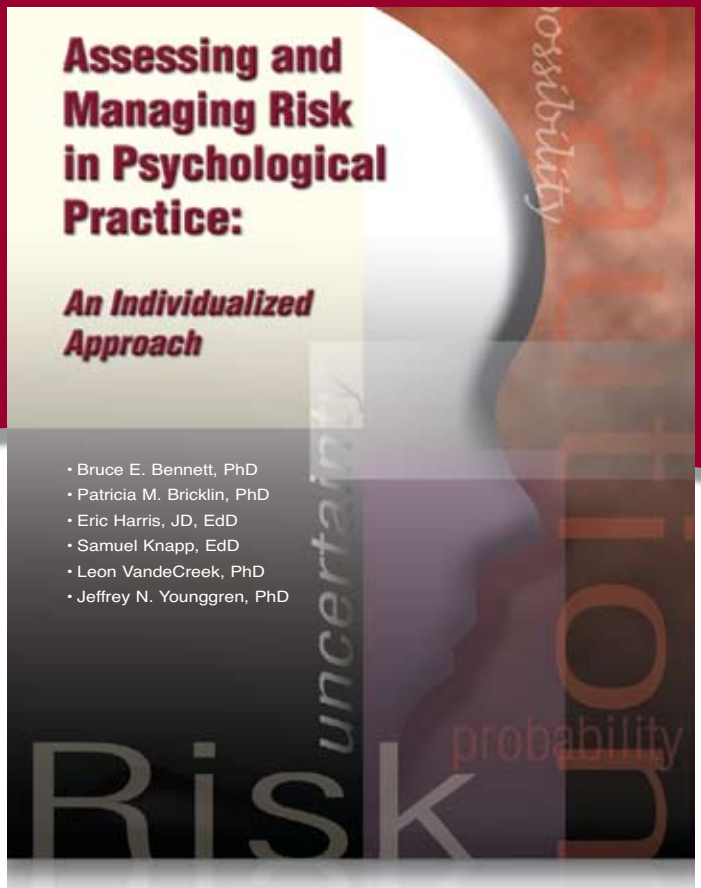

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TRAUMA PSYCHOLOGY NEWSLETTER

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

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DIVISION 56
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