

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

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Presidential Voice

Onward to Orlando

Terence M. Keane, PhD

It's May and the flowers and trees are in bloom in New England and last week I registered for the American Psychological Association's (APA) annual convention in Orlando and made hotel reservations. *Tempus Fugit!*

Our conference this year is filled with some outstanding symposia, workshops, and posters. Sylvia Marotta, Denise Sloan, and Carlos Cuevas comprised the leadership of the conference and what a great job they've done for us. I am deeply grateful for their vision, energy, and dedication to making this an outstanding meeting for the Division of Trauma Psychology.

Having given a couple of plenary addresses in recent years, I've chosen to chair a Presidential Symposium and allocate the time to a simply outstanding array of clinicians who are developing treatments for people with

Posttraumatic Stress Disorder (PTSD). Norah Feeny (Case Western Reserve), Gayle Beck (University of Memphis), Denise Sloan (National Center for PTSD & Boston University), and Deborah Beidel (University of Central Florida) will present new paradigms and new data on treatment outcomes from their remarkably productive clinical research programs.

We're delighted also to announce

that our Invited Addresses are on assessment and treatment of PTSD. Frank Weathers (Auburn University) and a key developer of the Clinician-Administered PTSD Scale (CAPS) and the PTSD Checklist (PCL) will discuss approaches to evaluate people with PTSD. Later in the meeting, Marylene Cloitre (National Center for PTSD–Palo Alto) will discuss her creative approach to intervention that is garnering a great deal of



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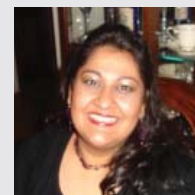
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Fall 2012 TPN Call for Articles



Simon A. Rego, PsyD

The Trauma Psychology Newsletter is accepting articles for the **Fall 2012** issue. All articles related to trauma psychology with a focus on theory, research, clinical or community applications, education and training, or policy will be considered. **Deadline is September 15, 2012.** Please limit length to 1,500-2,000 words, and send in MS Word or WordPerfect formats. Please include a 100-word author bio and high-quality photo (jpg or tiff) with your submission. Submit to Simon A. Rego, PsyD, Editor, at srego@montefiore.org or Renu Aldrich, MFTi, Associate Editor, at renu@renualdrich.com.



Renu Aldrich, MFTi

Effects of Trauma on Implicit Emotion Regulation Within a Family System: A Resiliency-Based Approach

Michael Changaris, PsyD

Traumatic events are far from rare. An epidemiological study found that 69% of individuals in the United States are exposed to at least one traumatic event in their lifetime (Norris, 1992). According to the study, 21% experienced at least one traumatic event in the last year. Trauma can expose difficulties in a family system that functions poorly, but can also negatively impact a family that functions well because traumatic events affect multiple domains of family functioning. Understanding resiliency factors can guide a clinician in developing interventions to facilitate the reduction in symptoms of trauma. A healthy family system can be a buffer against developing Post-Traumatic Stress Disorder (PTSD; McCubbin, Balling, Possin, Friedrich & Bryne, 2002). Safe supportive relationships can increase the chance that individuals will choose effective coping strategies, access appropriate health care, and will not isolate themselves from others (Betancourt & Khan, 2008).

PTSD in the Family System

Brief strategic family therapy practitioners (BSFT) assess families across multiple domains of functioning, including conflict resolution, family organization, and resonance (Szapocznik, Hervis & Schwartz, 2003). Symptoms of PTSD within one individual or multiple members of a family dramatically impact these domains. Conflict resolution skills are reduced by changes in Hypothalamic Pituitary Adrenal – Axis (HPA-Axis) reactivity. Increased startle response can escalate family arguments quickly. Avoidance-based coping can lead to unresolved conflicts and intense silences burdened with unmet emotional needs.

Family organization can be dramatically altered by traumatic events either directly or through profound changes in individuals' functioning (Ochberg, 1988). For instance, a father who has been supportive and nurturing might become brooding and quick-tempered after witnessing a death on the job.

Resonance describes patterns of distance and closeness in a family system. Symptoms of PTSD can alter families' ability to maintain and develop flexible boundaries. After a traumatic event, some families develop rigid boundaries, while others become highly enmeshed (Ochberg, 1988). Avoidance and numbing can create distance, making it difficult to feel

connected. As one individual in therapy with the author reported, "my heart does not feel anything when I see my (family member)."

In a family system, symptoms of PTSD, may lead to multiple alterations in how the family relates to the identified patient (IP). The individual labeled as the IP is often not the person directly exposed to the trauma. For example, a teenager may feel isolated and act-out in inappropriate ways when failing to connect with a parent who is grieving the recent loss of a loved one to cancer. At times, the individual who has symptoms of trauma has an intense shame reaction to being viewed as the IP, leading to a rigid pattern of acting out.

The developmental stage of a family can be altered by a traumatic event (Ochberg, 1988). Symptoms of trauma can lead family members to isolate themselves from others or be highly irritable at a time when their family needs support to manage the transition to a new stage of family development, such as the birth of a child.

Development of Emotion Regulation and Morality in Family Systems

The family is the training ground for learning emotional regulation and basic morality. Children learn to tolerate a wide range of emotional experiences through the rupture-and-repair cycle in family interactions. A child who becomes angry with her parents, but tolerates the emotions involved in resolving the conflict, strengthens her ability to handle anger and develops mastery experiences of affect regulation.

The ability to regulate emotions is a complex interaction between genetic, epic-genetic, and experiential factors. It is important to understand that emotional regulation is not a unitary construct, but comprises a range of skills and abilities. Some of the core domains of emotional regulation are auto-regulation (the innate ability to regulate emotions), cognitive regulation (the use of a conscious skill to change emotional reaction), co-regulation (the interactional regulation of emotions through relationships), and self-regulation (the integrated working of these three domains).

The ability to tolerate distress in order to maintain a relationship is a vital emotional regulation skill for the development of social and moral thinking. The consistent alternation in perspective taking between children and parents, as well as other family members, develops children's ability to anticipate the behavior of



Michael Changaris, PsyD

others, settle disputes, and understand cultural rules for displaying emotions.

Symptoms of PTSD fundamentally alter social interactions and moral choices. Franz Dwell (as cited in Preston & de Waal, 2002) stated that the complexity of human morality rests on two major factors: empathy and reciprocity. Individuals with symptoms of PTSD have profound alterations in both areas. Fight-or-flight activation reduces the ability of individuals to have empathy for another.

Symptoms of PTSD can alter patterns of reciprocity. Complex social animals support one another to reach mutual goals but expect repayment at a later time (Preston & de Waal, 2002). Fight-or-flight activation can lead to a privileging of self-needs over relationship needs, while numbing and avoidance can lead to the inability to repay the favor. These types of moral exchanges can lead to damaged relationships and negative spirals of family interactions. A chimp who helps a friend retrieve food but is not paid back in kind can exhibit negative social behavior as a consequence, including refusing support or food or moralistic aggression. In this way, a traumatic event occurring to a family member may lead to second-order change in the stability of the family system's structure.

PTSD is a normal reaction to abnormal life events. Even families with effective emotional regulation strategies are often not adequately prepared to support a loved one with trauma symptoms. Resiliency factors plus effective emotion regulation and secure family attachment can mitigate the risk of developing PTSD and aid in the treatment of trauma (Walsh, 2007).

Developing Family Resilience

There are multiple factors that improve families' ability to respond effectively to overwhelming stress (Hoge, Austin, Pollack, 2007; Walsh, 2007). Some elements of resiliency are:

- Intrapsychic factors within family members (e.g., emotional regulation skills, openness);

- Transactional patterns within the family (e.g., providing emotional support, decoding emotional reactions, normalizing and validation);

- Extended family system and friends (e.g., supporting the affected family members or indirectly affected family members, monetary support, practical support, problem solving);

- Mesosystemic factors, like churches and schools (e.g., contact with religious figures, support networks, problem-solving).

Trauma theory is a salutagenic, not pathogenic, model. While many individuals who experience traumatic events develop PTSD, many more do not (Bonanno, Galea, Bucciarelli & Vlahov, 2007). Understanding the family factors that increase resilience can support clinicians in developing effective family interventions.

Implicit Emotional Regulation in Family Systems

Emotional regulation is vital for family functioning, and a significant aspect of this is the cognitive appraisal of emotions. Because many arguments in families occur due to inaccurate cognitive interpretations, the family therapy interventions of decoding and reframing address this aspect of emotional regulation (Westen, 2000). The somatic marker hypothesis posits that there are two major neurological systems for processing emotions: a fast limbic circuit that appraises a situation in a global holistic manner, initially bypassing conscious awareness, and a slower emotional system that involves conscious cognitive appraisal of a situation (Bechara, Damasio, Tranel & Damasio, 2005). Porges (2007) expanded this theory describing what he called neuroception as the appraisal of threat or safety using the fast limbic circuit. Teens with PTSD were more likely than their peers without PTSD to interpret a facial expression of fear as a facial expression of anger (Rauch et al., 2000). Often the recognition of an emotion is non-deliberative and does not involve conscious processes (Zajonc, 1984).

While changing cognitive appraisal is an important aspect of treatment, the implicit emotional regulation system also has a profound impact on family functioning. It is not unusual for a body posture or a vocal tone to precipitate a family difficulty. For those individuals with PTSD, triggering events for fight, flight, or freeze states can be subtle and sensory-based (van der Kolk, 2006). For instance, one individual noted in treatment with the author that slowed movements and slurred speech triggered a sense memory of being assaulted by a man who was intoxicated. Tracking the implicit interactions between family members can allow clinicians to transform a re-enactment of a family pattern to a powerful corrective experience.

The non-verbal dance of communication is vital in a family system (Schore, 2001). There is a synchrony that develops in moments of attunement and leads to an experience of emotional connection and safety (Knyazev, Slobodskoj-Plusnin & Bocharov, 2009). Through supporting increased attunement, the cacophony of movements in an argument can turn into a smooth dance, as pupils dilate at the same time, breath synchronizes, and body posture once tense now mirrors another's. Elevated stress response and symptoms of PTSD both reduce the ability to enter into this dance, thereby reducing family resilience to stress (van der Kolk, 2006).

For many individuals with PTSD, the fast limbic system often does not shift to match their children's emotional experiences. Verbal decoding of children's experience without the authenticity of an emotional response can feel as if parents are faking their response, deepening the rupture. Clinicians witnessing this type of interaction can support parents to regulate their emotional state, scaffolding the parents into emotional resonance.

It is important to understand that the fast limbic system is not trained by dialog or information but by

emotional interactions (Smith & Ellsworth, 1985). This process results in a powerful opportunity for individuals to develop new patterns of emotional interactions and can be applied in family therapy.

Four key mechanisms identified by Schore (2001) that lead to increased effective implicit interactions are:

Rupture-and-repair cycle: Small relationship ruptures are followed by reconciliation and implicit attunement;

Decoding empathy cycle: Emotionally matching children's affective state is followed by decoding children's experiences that are tied to this affect, and then re-attuning the affective state to match any shifts in children's emotions;

Implicit boundary setting: The most obvious form of this type of boundary setting is "the look" parents give to children, which lets children know that they are pushing their parents' limits;

Modeling emotion regulation: Opportunities for corrective emotional modeling for both parents and children are provided via limbic system training.

Implicit Family Therapy Interventions to Increase Resiliency

PTSD affects multiple dimensions of family functioning. One of the underexplored aspects of family therapy is the impact of a fast circuit or implicit emotion co-regulation on a family. Therapists can develop skills to recognize implicit emotional exchanges, develop effective interventions, and support the development of resilience in the family system.

Examples for the major domains of implicit family system interventions are listed below:

Tracking skills: Identifying implicit regulation patterns; identifying transitional moments (e.g., when the family is on the verge of entering a destructive pattern); identifying implicit triggers (i.e., watching for the sensory cues leading to affective responses); identifying attunement (e.g., the moments when the family is functioning well); and identifying pro-social emotions (e.g., allowing the therapist to privilege effective interactions shifting the hedonics of interactions);

Enactment-based skills: Slowing down the interaction, validation, coaching empathy, changing proximity, and offering physical support;

Psychoeducation: Understanding how the fight-or-flight response works, learning about dissociation, seeing the different ways that other family members express love, and valuing the importance of play;

Home practice: Playtime, quiet time, argument pauses, and time to appreciate the efforts of other family members.

Conclusion

Increased psychological distress in a family member creates profound alterations in family interactions (Walsh, 2007). The majority of individuals

will at some point be affected, if only for a brief time, by a traumatic event, and unregulated symptoms of trauma can affect generations to come. Understanding the impact of implicit emotional regulation can lead to developing effective tools to increase family functioning and support a family to aid in the resilience of individuals with symptoms of PTSD.

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Our Children Are At Risk and Their Health Is Endangered: What Are Their Legal Rights, How Do We Hold the Courts Accountable to Protect Them, and What Can Psychologists Do?

Editor's note: This column discusses legal issues related to Trauma Psychology. The author welcomes comments as well as questions to be addressed in future issues.

Toby Kleinman, JD, toby@adlerkleinman.com

I am the daughter of one of New Jersey's very first licensed psychologists. My father received his PhD in psychology from NYU, assisted in writing the NJ licensing law, was President of the NJ Academy of Psychology, and was NJ's first behavior therapist, having worked closely with Joseph Wolpe. My father was a quiet and gentle man, one that people liked. He taught me the ethics of life and the imperative of being true to what you really are. I remember my father saying how long change took for psychology, and I have always admired that they continue to self-examine! As a lawyer, it is in this vein that I strive for the protection of children, and I rail against those who do not hold their ethics in such high regard.

Again and again in Family Court, I see psychologists without adequate training in evaluation of child abuse or custody issues giving "expert testimony" based on scientifically unfounded theories. The disheartening result is that the concerns of protective parents are ignored and children are placed in the custody of abusive parents. I would like to raise some questions about how the profession might assure that psychologists offering expert testimony in Family Court have the requisite education and experience to make evaluations and recommendations that are in children's best interests.

Josh Powell murdered his children while he was at the center of a criminal investigation for his wife's disappearance and likely murder. I do not believe that any judge ever expects the case before him will eventuate in the death of a child or a spouse. No judge expects a Josh Powell. No judge in a divorce action ever expects a respected member of the community to be a Jerry Sandusky and to have abused his or others' children. But similar perpetrators are before judges

every day, getting away with crimes against children. Psychologists play a critical role, since judges rely upon their expertise (or lack thereof) when they enter orders with regard to children.

The courts do not have expertise in the many areas of science, and so they rely on the testimony of "expert witnesses." The court places great reliance upon expert psychologists to assist in making decisions about the welfare of a child. What the psychologist opines often becomes the law of the case, and it becomes difficult, if

not impossible, for either parent to overcome during the pendency of a case. Psychologists have an immense share of the power in how the courts succeed or fail in protecting the welfare of children. Thus, the profession of psychology has a responsibility to maintain standards of practice for its members who testify in child abuse and custody cases.

During any divorce in any state in this country, children's best interests are supposed to be preserved. But all too often, best interest gets turned on its head where there are allegations of abuse during

divorce. It is here that psychologists play a critical role in assisting the court, and great reliance is often placed upon them. Because of this crucial role, psychologists should never overstep their actual expertise, training, and experience, nor should they ever promulgate unfounded, "junk" science.

It is difficult to enforce ethical guidelines, and sanction by psychological associations has no legal force. Would it be feasible for licensing boards to create mechanisms for accountability, perhaps to craft rules and regulations that forbid psychologists from making recommendations to the court outside their expertise? Without such restrictions, psychologists often proffer unfounded opinions in court that can promote harm to the very children who are the subjects of their evaluations. At present, under the rules of court, anyone with more than a layperson's knowledge may be permitted to testify as an expert. Unless the psychological profession prohibits testifying outside one's expertise, perhaps by licensing board sanction, there is no way to safeguard children's best interests when



Toby Kleinman, Esq.

psychologists perform custody evaluations for the court.

The 4th amendment of the Constitution says it is the “right of the people to be secure in their persons, houses, papers, and effects,” but a citizen child does not have the right in any divorce action to object to any violation of his/her rights to be safe and secure in their own home. Our most vulnerable of citizens, children, are sent by judges every day against their will, to homes of parents who harm them. Too often, so-called experts use junk science like Parental Alienation Syndrome (PAS) to remove these children from good and loving homes and place them with abusive parents.

The 14th amendment makes children born in the United States “citizens,” entitled to both due process and equal protection. However, judges are charged with sitting as *Parens Patriae*, as if the judge were the parent making the best decision for the child. When a judge relies on an expert, he/she expects the expert to rely on accepted standards of practice in understanding what has happened to a child and what has occurred in the home. This is especially important where there are allegations of specific risk to any child in a parent’s care.

Children do not have the right to a lawyer, nor do they have any specified rights, except as interpreted by a particular judge in a divorce action. Therefore, it is crucial that an expert is trained and knowledgeable in all of the areas in which he is opining. Still, too many psychologists accept the designation as court-appointed expert without actually knowing the science of abuse.

Often a parent repeats a child’s words regarding abuse suffered, and makes a complaint him/herself during a divorce. That same parent risks becoming a suspect of PAS, a syndrome that does not even exist, except in the view of expert witnesses with inadequate training in child abuse and custody issues. Even when expert testimony includes misinterpretation of science or conjecture, it is still relied upon as fact by the court, often resulting in depriving the protective parent of custody.

Made-up syndromes and other theories of conjecture such as PAS and estrangement are often used as though they were relevant to determining whether or not a child has been abused. These self-identified experts fail to testify that the best way to determine abuse is through an interview with the child; neither do they testify that accepted practice does not require an interview with the accused parent. Despite the fact that there is no scientific evidence for PAS, these experts present alienation and/or estrangement as though they were alternative hypotheses to the actual occurrence of abuse. There is no science to show that either alienation of a child from a parent or estrangement between the two is even relevant to the issue of abuse. It is well settled that interview and examination of children themselves are the best determinants for whether or not abuse has occurred—indeed, it is not even necessary to evaluate the named offending parent. But psychologists who raise these alternatives often disparage the child’s own voice and the accuracy of a child’s report of abuse.

In the process, community scientific standards for determining abuse get pushed aside.

As a policy matter, psychologists can influence the courts to prevent accusations that divorcing parents who raise questions of abuse are alienating or causing estrangement. Such accusations are conjectural. They become attacks against the protective parent’s character and have no bearing, for example, on whether the accused parent has harmed the children. Research shows that most children do not lie about being abused by a parent. Yet frequently, psychologists who do not know this literature give opinions in court on these matters.

Psychologists have a duty to practice only within the scope of their training and experience. Yet, without some means of establishing their expertise to testify on these matters, there is no way for the profession to maintain a high standard of conduct. Because lawyers take cases as advocates and are not experts in all fields of practice, and because there are many cases put forth by pro se litigants (acting as one’s own advocate), it is important that psychologists themselves play a role in oversight. Currently psychologists can take classes in forensics or qualify for higher standards such as ABPP, but they are still self-regulating when it comes to determining whether they have the expertise to testify. Possibly licensing boards could regulate this through the passage of strict regulations whereby psychologists must establish that they have the relevant credentials before they are permitted to testify in specialized areas. Richard Gardner, the originator of the theory of PAS, might have been kept from qualifying as an expert had the medical board held him to account for opining on his own theories even though they had not been substantiated by research.

As things stand now, family courts believe that children have their safety needs met in the center of custody litigation between parents—often between parents of unequal power. When a parent raises the question of abuse after a disclosure of abuse by a child, the divorce court is the perfect setting for “attack dog” litigation—the protective parent becomes the target of attack, and the child’s disclosure is attributed to the parent. The abuse issue often gets merged into the custody litigation as though it were a part of the custody matter. While guidelines for custody evaluations provide standards for forensic work and testimony, the means for enforcing these standards have not been adequate to protect children.

The child has no right to appeal absent permission of the court. The child cannot object to any order affecting them. The child has no absolute right to cross-examine or seek redress of grievances as granted to them as citizens by the 1st and 5th amendments. Thus, without an expert holding to a rigorous standard prior to conducting a forensic evaluation, the courts merely have the lawyers or a pro se litigant asking questions. This leaves open too much room for children to go unprotected where they need protection. Our courts essentially

seize young children without regard for their will and without standing to object, and send them to be battered. This can be stopped if psychologists are willing to step forward to create and enforce specialized rules to apply to these cases.

Where children's rights are denied and they are sent to live with batterers in contravention of their 4th amendment right under the US Constitution, "To be secure in their persons, houses, papers, and effects," and the good parent is then deprived of protecting their child, I blame the courts. I also fault the professionals involved, because even where the laws are on the books and the guidelines are in place, they cannot be properly implemented where there is no real accountability by the professional organizations of the experts who testify.

Psychologists can implement procedures and regulations that licensees must follow and they can be required to report all limitations in their expertise to the court before undertaking any court appointment or private appointment. Perhaps they can be required to take an additional test post licensure in special areas of practice before they are permitted to testify.

There are social and cultural assumptions that need to be overcome in pursuing all claims, and psychologists properly trained can assist with these as well. For example, protective parents who bring the issue of abuse to the attention of a court are sometimes accused of attempting to get "a leg up" in a divorce or custody matter by raising child abuse. Where the protective parent comes under scrutiny and the perpetrator named by the child is allowed to attack him/her, the court unwittingly exacerbates the abuse.

I have come to believe that the change we need cannot be won in the courts on a case-by-case basis alone. No single story tells the world what parents trying to protect their children are facing daily in courts across the country. Protective parents are losing their children in custody cases while perpetrators gain the court's imprimatur to continue to abuse. The news media rarely cover abuse or custody cases unless there is a death. Their legal departments shy from these cases, assuming them to be "he said she said" stories. There is an expectation that if the court believed a child was abused, it would protect the child. After all, we live in a country that believes in and relies on its system of justice, so we assume justice must have prevailed or a bad parent would not have the custody of the children.

Psychologists can hold members of their community accountable by creating community standards for expertise in child custody matters where child protection is involved. Because of the difficulty in holding psychologists accountable to ethical guidelines for custody evaluations, should licensing boards establish special standards of knowledge psychologists must meet before providing expert testimony regarding children? This would make it more difficult for unscrupulous psychologists to claim they are experts in child abuse. Perhaps there should be a separate license for forensic psychology, as there is for school psychology, with

recognition for specialty in areas such as domestic violence and child abuse and where testimony in these specialty areas is prohibited absent specialized training in these specialized areas.

While licensed psychologists may already be required to maintain the most current knowledge, perhaps there could be a way to require and enforce psychologists' obligation to disclose the limitations of their training and experience to the court, and to require that they refuse to opine on any issue where they have not been specially trained. Our children deserve nothing less.

***Toby Kleinman** is a NJ attorney and has consulted in over 45 states. She is an Associate Editor of The Journal of Child Custody, has published articles in The New Jersey Law Journal, taught at the Harvard School of Public Health, is a director of the Leadership Council on Child Abuse and Interpersonal Violence, served as the Professional Liaison to Division 56, is on the Board of Advisors of the DV Leap at GW Law School. Ms. Kleinman has presented at IVAT, AFCC, the Battered Mothers Custody Conferences as a keynote speaker, and has trained family court judges. Ms Kleinman has also been voted a New Jersey Super Lawyer and is called as a guest expert on network television. ■*

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***Michael Changaris, PsyD**, incorporates trauma theory into his work with families and children in Northern California. He also integrates affective neuroscience with evidence-based treatments, conducts trainings on mindfulness, and provides psychotherapeutic treatment for elders and families addressing end-of-life issues. ■*

International Committee: Interview With Vincent Sezibera, PhD

*Elizabeth Carll, PhD, Chair,
International Committee*

The mission of the International Committee is to insure that international issues are represented in Division business and policies and to foster international collaboration and communication concerning trauma-related issues. The committee has a number of projects underway. In an effort to include the next generation of psychologists, we actively recruit student members to participate in committee activities, including conducting interviews with trauma psychologists who reside outside of the United States. This interview project has been ongoing over the past couple of years and was developed by former chair, Kathryn Norsworthy, PhD.

The interview below conducted by student member Sarena Loya is an excellent example of disseminating information about how trauma psychology is practiced and perceived in Rwanda. Dr. Vincent Sezibera has collaborated on research with Dr. Carl Auerbach, who is a member of the International Committee. Student members of the International Committee will also have an opportunity to submit posters for the 2012 APA Convention in Orlando.

The committee is also collecting information on international trauma psychology programs both within the US and globally. The programs in other countries will give insight as to the practice and research relating to international trauma psychology. If you are aware of such programs, which are university based or established as ongoing institutes, please send the information to Dr. Elizabeth Carll, Chair, Division 56 International Committee, at ecarll@optonline.net.

*Interviewer: Sarena Loya, MS,
Student Member of Division 56*

You cannot teach someone who is not hungry what starvation is.” This was the analogy that Dr. Vincent Sezibera, Rwandan trauma expert, used to describe the shock and pain of the Rwandan nation and the relationship to PTSD following the 1994 genocide in which the lives of over 800,000



Elizabeth Carll, PhD



Vincent Sezibera, PhD



Sarena Loya, MS

people were lost. He also stated that prior to the genocide of 1994, “Mental health equaled madness.” Now, a mere 18 years later, the story has changed quite a bit.

Dr. Sezibera began his career in the field of trauma psychology in 1997, in response to the severe mental health repercussions that the 1994 genocide had on the Rwandan people. In the wake of the severe trauma that permeated the country, he worked with a community mental health program called Programme de Santé Mentale Communautaire (PSMC). This program was established through the National University of Rwanda to help restore the nation’s mental health. He is interested in the role of PTSD as a complicating factor in the grieving process for both adults and children. From 1999 to 2002, he worked for the International Rescue Committee (IRC), a US-based organization, assisting children who had been estranged from their parents following the genocide. He also trained Rwandan social workers on the short and long-term effects of PTSD. After completing his Master’s and PhD at the Catholic University of Louvain, Belgium in 2008, Dr. Sezibera returned to the National University of Rwanda, where he is now the head of the department of clinical psychology.

The 1994 genocide against the Tutsi caused the Rwandan community to begin reflecting on the concept of PTSD and trauma, according to Dr. Sezibera. He explained that prior to the genocide, the perception of mental health was that “mental health equals madness.” This meant that only those with severe mental illness sought treatment and those individuals were placed in isolative psychiatric wards. The repercussions of the genocide, which include high rates of PTSD and co-morbid impairments, facilitated a changed and refreshing perception of mental health. Although PTSD was most acute and prevalent

in the population immediately following the genocide, the effects persist. According to Munyandamutse et al. (2012), 26.1% of the general population in Rwanda currently meets the DSM-IV criteria for a PTSD diagnosis, which is frequently accompanied by major depression, substance abuse, and suicide attempts. Some clinics are reporting somatic PTSD symptoms, which are

manifesting as epilepsy with no apparent neurological basis.

Those suffering from post-genocide trauma include both individuals who were directly and indirectly exposed to the war. Individuals who were adults during the genocide continued to suffer from loss and chronic PTSD and those who were children or adolescents are now beginning to feel the traumatic effects set in. Even children who were born after 1994 show some signs of PTSD, suggesting that this may be a result of intergenerational trauma and secondary traumatization.

In most African countries, mental health is perceived as a consequence of supernatural forces or demonic possessions and the approach to healing revolves around consultation with traditional healers and engaging in community-specific traditions. Though this attitude remains in Rwanda, the increased public education regarding trauma has reduced stigma and encouraged the population to gradually open its mind to a more Western perspective towards mental health.

In the aftershock of the genocide there is a strong cultural emphasis on community. Rwandans hold relationships with neighbors and other social relationships in the highest regard and rely on one another above local authorities in any trying context. The pervasiveness of trauma is perceived as a community problem as opposed to an individual issue. Specific cultural traditions are integrated into PTSD and psychosocial treatments, differing greatly from the Western perspective of traditional theoretical orientations. Conflicts over the genocide are frequently addressed with a Rwandan practice called the “Gacaca,” a custom of conflict resolution in which a mediator assists two conflicting parties in negotiating a solution and developing a social contract to facilitate their living together peacefully.

Genocide continues to be a main theme integrated into Rwandan daily life. All people in Rwanda have been affected by genocide in some fashion and memorial sites and organizations for survivors, students, and women have a strong presence in the community. Furthermore, the month of April marks an annual commemoration of the genocide in which communities perform various cultural and ancient rituals including mourning and singing in support to grieving survivors.

In addressing the long-term aftermath of the genocide, Dr. Sezibera explained that there is a “never again” mentality and a dedication to discouraging genocide worldwide. He noted that “The genocide opened wounds but also opened minds,” stressing that the people of Rwanda are committed to learn from their recent, tragic history. He stated that if there is one positive outcome of one of the gravest tragedies in history, it is the newfound welcoming attitude towards mental health, which supports greater awareness for and treatment of trauma. It is hoped that this new perspective on mental health will continue to grow and improve the lives of many Rwandans who suffer in silence.

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Sarena Loya, MS, is a second-year doctoral (PsyD) student in clinical psychology at Loyola University, Maryland. Sarena graduated with her BA in psychology from the University of Maryland, College Park. She is currently working at the Loyola Clinical Centers in Baltimore, Maryland as a psychotherapy clinician for adults and as a psycho-educational assessment clinician for children and adolescents. Sarena is interested in the impact of trauma on psychosocial development in young adults, as well as in the development of international trauma intervention programs.■

Division 56 Roundtable Discussions

During the APA Annual Convention in Orlando this year, Division 56 will be hosting a number of roundtable discussions in its hospitality suite. The aim of these presentations is to present on a specific topic relevant to members of the division in an informal and interactive way. The topic areas and presenters include:

- *Successfully Applying for Grant Funding*
Ronald Acierno, PhD
Diane Castillo, PhD
Brian Marx, PhD
- *Forensic Practice in the Area of Trauma and PTSD*
Constance Dalenberg, PhD
Dawn Hughes, PhD
- *Getting Published in Scholarly Journals*
Robert Geffner, PhD
Steven Gold, PhD
Sherry Hamby, PhD
- *Self-Care in Trauma Practice*
Christine Courtois, PhD
Charles Figley, PhD
Richard Tedeschi, PhD
- *Developing and Maintaining a Trauma-Focused Private Practice*
Lisa Rocchio, PhD
Sylvia Marotta, PhD
Laura Brown, PhD

For more information, please contact Carlos A. Cuevas, PhD, at c.cuevas@neu.edu or 617-373-7462.

I Have Graduated, Now What?

Considerations and Tips for Beginning a Private Practice

Nicole C. Winters, LICSW, PsyD

As the healthcare field evolves, many Early Career Psychologists (ECPs) are considering the risks and benefits of starting a private practice. When my classmates and I discussed the possibilities, we considered the type of work we wanted to do and the practical issues involved in running a practice (e.g., cash flow and obtaining private health insurance). Knowing that I wanted to have a private practice, I tailored my internship and post-doctoral training to allow me to explore that option and also sought advice from mentors who operated private practices.

Recently I had the opportunity to interview Laura Brown, PhD, ABPP, and Bill Heusler, PsyD, on their thoughts about private practice. Both have a strong trauma focus in their practices and both are very involved in mentoring and training new clinicians. Dr. Brown has been in private practice for over 30 years. She founded the Fremont Community Therapy Project, a training clinic that offers low-cost therapy and assessment services. Dr. Heusler is in private practice in Snohomish County, Washington. He enjoys supervising students as they develop skills in both assessment and therapy services.



Nicole C. Winters, LICSW, PsyD

1. What are the common pitfalls that you see people make when starting a private practice?

Laura Brown: Spending too much money on fancy furniture, preprinted letterhead, business cards, and an expensive location where clients have to pay for parking. Keeping your overhead down is the smartest thing you can do to start.

Bill Heusler: Making assumptions about things such as insurance panels (that they'll take you) and clients (that they will come if you're licensed and that being licensed is enough).

2. What are your thoughts on taking insurance or not?

Laura Brown: If you can take insurance, then you'll be accessible to people who may only be able to

afford the co-pay, but not the full fee. If you have a well-developed specialty and are one of only a few people in your area with it, then you can probably afford to go all fee-for-service. But if you can get on insurance panels—even though they often offer very low reimbursements—it will make you available to a broader range of clients. Check into what the out-of-network benefits are for large employers in your area as well, as they are often good enough that [as long as you are insurance eligible] people will come and pay the slightly higher co-pays in exchange for getting a high-quality service.

Bill Heusler: It depends on how much you have in the way of resources when waiting for fee-for-service clients to come in. I used to do marketing for mental health practitioners, so I have watched this. Contrary to how we would think, if you situate yourself in a

wealthy area, they actually have the highest default rate. Right now, I have 20-30% fee-for-service clients. I take money when they arrive. I have a colleague stuck with \$15,000 in unpaid bills. We assume people can or cannot pay their bill and often we're wrong.

3. What are some strategies for those who want to join insurance panels?

Laura Brown: Be what they want. Work with children and adolescents, be bilingual, be located in areas with few other therapists on their panel, and demonstrate you have something unique to offer.

Bill Heusler: Hook up with a group of psychiatrists. You can also try to find people on panels or get hired by a group and get in under them. Beware though, once you are on a panel, you cannot go out on your own and remain on the panel. If you are waiting to get on a panel, call them every month as they will not call you to tell you when they have openings. Many panels won't accept you until you have been licensed for a few years. You might also consider Employee Assistance Programs (EAPs), as if they get familiar with your name, they might pass it on.

4. What about building a fee-for-service practice?

Laura Brown: Having never done this myself, I'm not a great resource. What I see is that it takes being

willing to be very lean for a long time, and doing a lot of things to make yourself visible.

Bill Heusler: This is an area in which forensic work for attorneys is good. Make sure you have an agreement, and have them sign it before doing anything for them. Part of the agreement needs to be that you will turn them in to the Bar Association for failure to pay because for lawyers it is unethical not to pay you. Always indicate you will turn them over to collections, even if you intend to operate in a caring way. Be explicit in the agreement and accept money up front.

5. What are the advantages and disadvantages to joining an established practice versus being on your own?

Laura Brown: It depends on your temperament. If you're a solo performer you may have a hard time working in a group. If you're joining a group that's established, be sure that you're not being brought in to be their cash cow; be an equal partner in the business. Forming a new group with peers is often a good way to go if you know you work better in a group setting.

Bill Heusler: Getting automatically on insurance panels and having people to refer to, such as psychiatrists, is a great advantage of being in a group practice. You also have the opportunity to consult every day. I often just stop someone in the hall to consult with them; it is the informal consulting on the fly that can be so great about a group.

6. What recommendations do you have regarding legal matters and office space?

Laura Brown: Legal matters: Know how the law pertains to everything you do and have a legal consultant who understands psychology practice. Most state association newsletters have ads from people who do this work. Be sure that you have consent forms for each and every service that you provide! Office space: Get an office that is welcoming and not expensive. If you can find an office near a public transit line, do so. It makes you more accessible.

Bill Heusler: Legal matters: Find a CPA or business lawyer who likes small businesses. I made an LLC myself, but a professional could have explained the tax implications of an S-Corporation. The Department of Revenue explains the differences on their website. In some cases, you will be paying yourself a paycheck, which means you need to understand payroll services. Office space: Try to avoid a lease. I joined a practice where we paid 30% of what is collected, which was a pretty good deal in the beginning. You can also try to sublet from another psychologist.

7. What recommendations do you have about

building a primarily psychotherapy or assessment focused practice (or the combination thereof)?

Laura Brown: Assessment is a fee-for-service business that only psychologists can do. If you're good at assessments and can write high-quality reports then you will have a source of income that will get you over the hump of starting a therapy practice. Social security always needs people to do assessments. Part of why I train my interns so intensively on assessment is that it's a money-making proposition that doesn't require you to be on insurance panels. In addition, being a good assessor makes you a better therapist and vice-versa.

Bill Heusler: I've never done a huge assessment practice, so I am not sure of the risks or how it could pay off. Also, there is no reason to do group therapy with people who have insurance. The reimbursement is too low. You'll be in a room doing more work with more people for the same amount.

8. What kind of advice do you wish you received when you opened your practice?

Laura Brown: Any advice at all! I had none. It would have helped to know how to bill (hire a good, cheap billing person who specializes in mental health, or use some of the free services that are available). It would have also helped to have someone make me think through whom I was associating myself with. I spent my first few years in a space that was very inexpensive, but I was sharing it with some people who turned out to be a tad shady.

Bill Heusler: I didn't get any! I thought I knew everything, but boy was I wrong. I was set up in private practice because of my internship, so I just stayed on. The supervisor gave me a good deal on rent to help me get started. I owe her a lot. Then Bay Psychiatric Center (group practice) fell in my lap.

9. What resources (websites, books, articles, consultants) would you recommend Early Career Psychologists look over before making a decision?

Laura Brown: I would get local consultation from an experienced therapist who has a practice that is similar to the one you want to have. APA's practice directorate website and the APA's Division 42 (Independent Practice) website are full of useful tips and resources.

Bill Heusler: As much as you can, offload tasks to those who know more. I don't have an MBA, so I let someone who does handle those parts. You will pay more to fix a screw up. Billing is another area in which the choices are many. A billing service is sometimes offered to members of a group practice. For instance, now I pay 7% for billing at Bay Psychiatric Center (group practice).

You can get it from outside agencies for 5-6%, but I like to have them right in the office so I can ask questions. Have a therapist available for you, especially when doing trauma work. The trauma load accumulates over time. Variety is the best thing when starting your practice.

Conclusion

The decision to start a private practice is only the first step. As Dr. Brown mentioned, choosing a location is important. In fact, it should be the first decision you make after committing to private practice, because you will need an address to put on insurance panel applications and business cards. Your office location should be accessible to clients with whom you want to work. Make sure that you put enough effort into marketing your services. One way to do so is to develop a website and advertise your services, which requires careful thought and consideration before moving forward (for an overview, see Bailey, 2011). Think ahead about using your cell phone as your business line. It can be portable as you quickly grow into a bigger office, but people will have access to you at all hours of the day. I also suggest keeping a part-time job while starting

your practice to avoid the financial panic that can come during the first few years when you are just starting to get clients and insurance companies take 30-90 days to pay you.

I wish to express sincere thanks to Drs. Brown and Heusler for their willingness to share their thoughts with ECPs. They have both shown endless patience and enthusiasm in working with trainees and ECPs in the Seattle area.

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Nicole Winters earned a Master of Social Work degree from the University of Washington, Seattle. She worked for Child Protective Services for nine years while pursuing her clinical training. Dr. Winters received her Master of Arts and Doctorate in Clinical Psychology from Argosy University, Seattle. She is currently in private practice, working equally in assessment and therapy. ■

Report From the APA Council of Representatives Annual Meeting

Sandra Mattar, PsyD, and Joan M. Cook, PhD

The Council of Representatives met February 23-26, 2012 in Washington, DC. We welcomed the new APA President, Dr.

Suzanne Bennett Johnson, who served as presiding officer. She updated the Council on her three presidential initiatives, which focus on the obesity crisis, attracting early career psychologists to APA, and the need for more interdisciplinary collaboration between practice and science.

APA has initiated a good governance project to evaluate the current structures and to maximize effectiveness to meet the needs of our organization in the 21st century. The council devoted some time to discussing the importance of becoming engaged in strategic issues that are relevant to the discipline, such as the role of technology in psychology and ways to engage the next generation of psychologists. Some suggestions included using social media in public education, training psychology faculty in new technologies, delivering research findings through technology, and the role of new technologies in data-sharing.

APA's CEO Norman Anderson presented his seven strategic initiatives for the organization: To enhance membership engagement and value; current and future demands for the psychology workforce; develop and disseminate clinical treatment guidelines; expand the public education campaign; promote

opportunities for graduate and continued professional development to advance psychology in health and interdisciplinary collaborations; increase support for research on health disparities; and forge a strategic alliance with healthcare organizations to include psychologists.

Other highlights of the meeting included:

The council approved funding to continue the work developing telepsychology guidelines;

Approval of two journals: *Practices and Services Delivery in Pediatric Psychology* (Division 54 journal) and *Translational Issues in Psychological Science* (an American Psychological Association of Graduate Students journal);

Receipt of the report of the 2011 Presidential Task Force on Immigration;

Receipt of the report of the 2011 Presidential Task Force on Diversity and Discrimination;

APA staff presentation of new products offered to APA members and the general public: PsycVIDEO, PsycTESTS (test instrument finding database), PsycNET, mobile initiative (APA journals for iPad, iPhone), and a *Precise Psychology Dictionary*.

Please remember that we are your representatives to the APA. As such, we represent trauma psychology's interests in Council discussions, Task Forces, and Committees. If you have any questions or concerns, please feel free to contact us: sm26@stmarys-ca.edu or Joan.Cook@yale.edu. ■



Joan M. Cook, PhD

Student's Corner: Bringing Trauma Assessment to Your Practicum Agency

Alexis V. Arczynski, MS
University of Utah

Throughout my clinical training as a feminist multicultural (FMC) counseling psychologist in both community mental health centers and university counseling centers, I have worked toward the goal of specializing in trauma and have been driven to enhance my skill in providing assessment services. My current practicum site, an FMC-oriented trauma-centered site, does not provide assessment services, so it has been a difficult yet rewarding task integrating trauma assessment.

In this column, I will articulate my process bringing trauma assessment into an agency that has historically not delivered assessment services as a model for other trainees. Thus, I will (a) describe the important relationships and information I needed as I built a trauma assessment practicum, (b) discuss the steps I took to build the trauma assessment element into my practicum, and (c) describe the lessons I learned throughout this process.

Relationships and Knowledge

Obtaining practicum experience relevant to my professional goals of enhancing my trauma and assessment training required both developing relationships and specialized knowledge. It was through key relationships with the staff at my practicum agency that I acquired information on how to build trauma assessment into my practicum responsibilities, obtained approval from the staff, and had systemic support when I encountered difficulties and needed client referrals. The specific knowledge I found helpful in introducing assessment training to my agency included a strong understanding of the agency's policies for practicum training, an accurate assessment of the clinical staff's ability to provide supervision for assessment, and awareness of the elements necessary to integrate assessment into their procedures. These areas were especially important in my scenario because of the training agency's FMC orientation. For example,

I needed to incorporate an understanding of the discrepancies between power and privilege due to social locations (e.g., gender or ethnicity/race), and focus on the collaborative process in an assessment relationship with a focus on client empowerment in order to be consistent with the training mission of my site (Brown, 1994, 2010; Worell & Remer, 2003; WRC, 2012).

Building an FMC, Trauma-Centered Assessment Practicum

The site's clinical coordinator acted as my primary consultant and advocate for the trauma assessment practicum. She assisted me in developing a proposal to present to staff and provided feedback on the assessment procedures and policies. I found her guidance integral to the effectiveness of the practicum. During our initial meeting, we considered two questions: (a) How will a trauma assessment practicum benefit our individual clients? and (b) How will it benefit the agency in general? Our responses to these questions helped us articulate how such a practicum would fit



Alexis V. Arczynski, MS

specifically within the site's training mission and more broadly within an FMC theoretical orientation. By being able to answer questions like these, other students may be better positioned to propose new elements into their current training.

In order to develop an appropriate trauma assessment battery, the first step was to examine the relevant literature. My goal was to conduct an integrative, therapeutic, FMC-oriented, trauma assessment on a budget—not an easy task! The assessment practicum needed to meet the American Psychological Association's best practice standards (APA, 2002) and also fully examine the effects of "early onset, multiple, or extended traumatic stressors" (Briere & Spinazzola, 2005, p. 401). Furthermore, it was important to meet the needs of the agency by integrating an FMC orientation into trauma assessment (see Santos de Barona & Dutton, 1997).

My trauma assessment practicum incorporated a flexible assessment battery. Batteries are often impacted by access to assessment protocols, funding, and prior training. I was fortunate in that I was able to procure

assistance from the UCC, the University's Testing Center, the local branch of the Veterans Administration (VA; see United States Department of Veterans Affairs, 2012), and Dr. John Briere (see Briere, 2012) to build the battery described below. To start, I utilized the Clinician Administered PTSD Scale (CAPS) as a trauma interview protocol (Blake et al., 1995) in addition to assessments that examined client responses to trauma, including the PTSD Checklist-Civilian (PCL-C; Weathers, Litz, Herman, Huska & Kean, 1993) and the Multiscale Dissociation Inventory (MDI; Briere, 2002). Next, I used the NEO Personality Inventory-Revised (NEO-PI-R; Costa & McCrae, 1992) and the Personality Assessment Inventory (PAI; Morey, 2007) as measures of personality function. Lastly, I utilized the Feminist Multicultural Therapy Outcome Measure (FMTOM) (Abousleman, 2006) to examine the client's level of empowerment and awareness of marginalization and privilege.

After developing the trauma assessment protocol, the next goal was to meet with the clinical staff to generate their interest. We hoped this step would help secure funding to make assessment less costly for our clients as well as provide a forum for discussing the logistics of the trauma assessment practicum. Once the staff's interest was established, I set out looking for appropriate supervision. I knew from the start that if I were to take on this project, internal supervision from my practicum site would be difficult given that the clinical supervisors did not have recent or extensive assessment experience. Therefore, I sought to augment their support through consultation with both the faculty in my department and the clinical staff at the University of Utah Counseling Center (UCC). It was in this way that I was able to create a network of supervisors from whom I could seek guidance relevant to the trauma, FMC, and assessment aspects of my practicum.

My final step was to develop referral and informed consent materials for use within my site. In order to facilitate a streamlined process with minimal interference to the already existing agency protocols, I obtained example materials from the assessment practicum at UCC to use as templates and integrated them with materials already in use for psychotherapy at my site. I then met with staff again to discuss the referral procedures, assessment materials, and to address any questions. This follow-up meeting was important because it allowed the staff to collaborate with me and let them know that I intended to uphold interview, assessment, report writing, and feedback procedures that fit the site's orientation to client services. For example, I believe the staff was encouraged by my intention to integrate client reactions and feedback into the interpretation and final written report. In doing so, the written report becomes a more relevant tool for later therapeutic interventions and maintaining the desired collaborative nature of the therapeutic relationship.

Learning

I learned many lessons throughout the process

of integrating assessment into my practicum experience. First, I learned that introducing assessment to an agency that has historically eschewed it is challenging. I was fortunate that the staff members became interested in the idea of an assessment process that centralized FMC principles and practice, but institutionalizing the assessment was a different story. Therefore, I would warn future trainees who desire to implement a trauma assessment into an existing practicum that institutionalization can be a long-term process that may be difficult to implement during the standard one-year-or-less practicum experience. Yet, I also want to share how empowered I felt when the staff started talking about the assessment and began contacting me with possible referrals. I felt a sense of achievement because I spearheaded this effort and saw it through to implementation.

Second, when bringing something new to an agency, be prepared to seek outside consultation. In my case, it was necessary to find many different consultants that each added their unique expertise and supported the different aspects of the trauma assessment practicum. It would have been difficult to find a single consultant to provide expertise in the areas of FMC, trauma, and assessment. At times it felt difficult as a trainee to integrate the fragmented supervision and consultation I received; however, it also felt exciting to consult with a diverse group of experts and to build my self-efficacy when synthesizing their direction and advice.

Lastly, the introduction of something new can be a demanding task for a trainee, and having agency support can go a long way in building determination to see a project through. I am grateful for the clinical coordinator of my agency as she supported me through the ups and downs of developing the trauma assessment practicum. When staff members stopped at my office door to ask how the process was going, I was thrilled! It was truly exciting to know that I had brought something to the agency that others saw as valuable.

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Social Justice: An Interview With Thema Bryant-Davis, PhD

The Division 56 Social Justice Task Force presents the first in a series of interviews with practitioners who have successfully integrated a social justice perspective into their work.

Renu K. Aldrich, MFTi

Thema Bryant-Davis is an Associate Professor of Psychology at Pepperdine University where she directs the Culture and Trauma Research Lab. She is past president of the Society for the Psychology of Women and Associate Editor of the Trauma Psychology Division's journal, *Psychological Trauma: Theory, Research, Practice, and Policy*. During her time as the APA representative to the United Nations, Dr. Bryant-Davis advocated for mental health globally. She is author of the book *Thriving in the Wake of Trauma: A Multicultural Guide* and editor of the book *Surviving Sexual Violence: A Guide to Recovery and Empowerment*. She has also served on the APA's Committee on Women in Psychology and Committee on International Relations in Psychology. She is a licensed psychologist and has a private practice in the Los Angeles area.



Thema Bryant-Davis, PhD

Q. Can you briefly describe what “social justice” means to you?

A. The committed work of creating a society or institution that is based on the principles of equality and solidarity, that understands and values human rights, and that recognizes the dignity of every human being.

Q. How do you define trauma psychology?

A. The study of experiences that overwhelm our ability to cope. It can include topics usually acknowledged such as war, domestic violence, and sexual assault as well as often-marginalized topics such as human trafficking, hate crimes, and societal trauma/intergenerational trauma.

Q. How did social justice and/or trauma work come to be important to you?

A. I grew up in the inner city of Baltimore, Maryland where trauma and injustices were prevalent. I also spent half of high school in Liberia, West Africa at the onset of the Civil War. In addition to exposure to these acts of community violence and national violence, I am also a survivor. I am a survivor of sexual assault, as well as multiple incidents of racism and sexism.

Q. How important is social justice to your work now?

A. Social justice work is central to my teaching, research, and clinical work.

Q. How do you incorporate elements of social justice into your work?

A. In teaching, I prepare my students to address social justice through assignments such as the development of research and intervention projects that address injustices and violations. Regarding my research and scholarship, I attend to activism, resistance, identity, and community support as well as the impact of oppression on the lives of diverse individuals across the lifespan. In my experience engaging in preventative efforts, I have found for the activities to be both effective and far-reaching, they must not be confined to the individual but cognizant of the greater context and systems. Feminist psychologists, community psychologists, and culturally responsive trauma psychologists recognize that the “problem” is not contained or created solely by individuals. In fact, PTSD is one of the only diagnoses whose criteria points to current mental health factors prompted by an external reality. As a social justice-oriented trauma psychologist, I attend to the individual and the circumstances that shape the individual's life, including oppression and marginalization.

Q. What helps you to facilitate social justice work, individually?

A. Engaging in social justice work as an individual helps to prevent burn out, powerlessness, and hopelessness. It can be discouraging if you just work with individuals in the aftermath of trauma. By

engaging in action to prevent violation, violence, and oppression, I am able to experience efficacy and to pass on that sense of empowerment to my students and clients.

Q. What helps you to facilitate social justice work within your organization?

A. I provide an orientation and ongoing dialogue with my research assistants to ensure they develop a critical lens that attends to the multiple systems intersecting in the lives of trauma survivors.

Q. What support and resources do you feel are necessary for more people to incorporate social justice into their work?

A. Psychologists need to have access to literature on social justice, a forum where psychologists share their various social justice projects, and institutional support for those who are in academic and/or clinical positions. It is also critical that psychologists start with self-awareness and remain open to learning instead of jumping in and attempting to be experts on other people's needs. Often those we label "resistant" have never been asked what they would like and what they feel they need. It is crucial that we acknowledge the aspects of our care that create barriers to engagement. We have to be careful not to engage in neo-colonialism masquerading as social justice.

Q. How familiar do you think your colleagues are with social justice principles and social justice literature?

A. I think the majority of trauma psychologists receive minimal training as it relates to social justice. We have to take the initiative to educate ourselves and to share what we learn in our scholarship and training programs as we let it inform our clinical practice.

Q. How well do you think the field of psychology has embraced social justice work? Has this changed in your opinion?

A. Social justice work is still greatly marginalized, but it is growing in both numbers and depth. Community psychologists have laid the foundation for decades and should be celebrated and recognized for their efforts as we continue to build on that foundation within the realm of trauma.

Q. What advice would you give to those who would like to incorporate more of a social justice ethic into their work?

A. I would encourage all psychologists to first look at the role that privilege and oppression have played in their lives and then begin assessing the impact on

clients, students, and/or research participants. In the immediate, it is good to explore the ways people cope with injustice, but coping is not enough. We have to also investigate ways to resist, dismantle, confront, and shift oppression and injustice. It starts on the individual level. Let us work against all acts of injustice within our organization, departments, and clinics. It is not enough to only fight against oppression against groups for which we are members. We have to combat injustice in all of its forms because, in the end, it harms all of us. As Judith Herman notes, it is easy to side with offenders. All they require is our silence. As we speak up about injustice and discrimination in all of its forms we turn the tide toward justice.■

Student's Corner

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Dattilio, F. M., & Freeman, A. (Eds.). (2007).
Cognitive-Behavioral Strategies in Crisis Intervention.
New York, NY: The Guilford Press. (556 pp). ISBN-13:
978-1606236482. \$35.00.

Daphny Ainslie, PsyD

In *Cognitive-Behavioral Strategies in Crisis Intervention*, Frank M. Dattilio, PhD, ABPP, and Arthur Freeman, EdD, ABPP, have composed an excellent resource for any mental health professional encountering a crisis situation. This compendium covers multiple areas where crises may be encountered and is well-written and accessible. The authors span the intersections of psychological crises, medically related crises, child and family crises, and environmental and situational crises. The text ends with a chapter regarding the relevant legal and ethical issues.

This text is intended for use by clinicians working in both outpatient and inpatient settings, but also can benefit researchers, active emergency and crisis response workers, and students in cognitive-behavioral therapy (CBT) and crisis intervention classes.

Within the book, a history of crisis and crisis theory is described by the authors. The emphasis is on helping the individual, couple, family, or group return to a pre-crisis level of functioning. Dattilio and Freeman suggest that typical methods of managing crisis situations are not as useful when psychologists encounter particularly distressing events. Because of this, the authors provide a theoretical and conceptual basis and rationale for utilizing a cognitive-behavioral approach in the delivery of crisis intervention services. Much of the focus is on viewing a crisis as a place for growth: an opportunity to work through a destabilizing event with the goal of returning to a previous level of functioning. CBT is deemed an essential modality because it is active, directive, goal-oriented, structured, collaborative, and focused on problem solving. This approach helps individuals minimize the potential for a radical outcome and urges clinicians to invite patients to think about crises as uncomfortable rather than catastrophic.

Crisis assessment as developed by Greenstone and Leviton is also explored by Dattilio and Freeman; particularly concrete steps on how to take immediate action, take control, conduct an assessment, decide how to manage a situation, and provide a post-assessment are provided. Four stages of crisis intervention include developing a collaborative relationship with the patient and building rapport; identifying the level of crisis of the situation along with the problems the individual is facing; helping the client create a plan for utilizing strengths and resources; and testing new ideas and behaviors.

This text provides a comprehensive overview of strategies for clinicians to use when working through various crises at many levels. The authors present the content in a thorough manner; the information is concrete and is highlighted by the use of tables, charts, and clinical vignettes. While various chapter authors comment on posttraumatic stress disorder (PTSD), it may have been helpful to provide a specific chapter on PTSD so that each chapter author did not have to repeat similar information.

Frank Dattilio and Philip Kendall provide a brilliant opening to the chapter on panic disorder with a clinical vignette for utilizing crisis intervention with an individual to produce a reduction in self-reported emotional distress. This description is helpful to understand how to put the technique into practice effectively.

Laurence Miller provides a very personal approach to working with law enforcement and mental health professionals. In his chapter on *Crisis Intervention Strategies for Treating Law Enforcement and Mental Health Professionals*, he opens with self-disclosure about his work training police officers. He also stresses the need to implement self-care for both law enforcement workers and mental health professionals. This dose of reality is heartening and is often overlooked when considering trauma work. Miller also does a fine job of clarifying the connections between physiological problems and concerns with psychological consequences. This type of description is imperative and provides a road map for those working with law enforcement. This process invites law enforcement and first responders to speak about challenges they are experiencing in terms of physical symptoms; this is especially helpful in environments where psychological symptoms and concerns are often stigmatized.

In the chapter *The Crisis-Prone Patient: The High-Arousal Cluster B Personality Disorders*, Gina Fusco and Arthur Freeman provide an explanation of how some people tolerate stress. The authors describe the difference between patients in crisis and crisis-prone patients. In a chapter on *Acute and Chronic Pain*, Sharon Morello Freeman describes the use of multiple inventories as interventions when working with chronic pain patients and provides information on other CBT strategies to use with patients in crisis.

The chapter on *Traumatic Brain Injury* by Mary Hubbard, Wayne Gordon, and Lynne Kosher explores the topic of medically related crises. In addition to doing an exceptional job of correlating anxiety with traumatic brain injury (TBI), the authors also provide modifications for CBT treatment for working with TBI patients. With the most recent conflicts ending (i.e., Operations Iraqi Freedom and Enduring Freedom), more and more TBI patients are being seen for mental health treatment.

Frank Dattilio, Elizabeth Davis, and Robert Goisman contribute a chapter on *Crisis with Medical Patients* that should have been the opening chapter within the medically related crises section of this book. This chapter highlights the intersection of medical crises and psychological and emotional symptoms. Their description of CBT technique implementation is helpful in revealing how stress exacerbates medical problems.

In their chapter on *Child Sexual Abuse*, Anne Hope Heflin and Esther Deblinger emphasize the need for multidisciplinary collaboration. Just one of the centerpieces of this text is a step-by-step guide to assist with treatment planning. *Spousal Abuse* was covered by L. Kevin Hamburger and Amy Holtzworth-Munroe in their examination of the effects of this abuse on the triad: the victim, the perpetrator, and the relationship. The complex issue of *Rape Trauma* is addressed by Elizabeth Muran. She discusses specific challenges faced by rape survivors as well as commonly used coping strategies of which clinicians should be aware when working with this population.

Arthur Freeman and Stephen Timchack wrote about *Anger and Aggression in Children and Adolescents*, addressing issues covered in the media, such as school shootings and bullying. The authors provide examples of how anger is ineffectively expressed and discuss interventions needed in the environment, culture, family, society, and in relationship with significant others. This systemic approach to the problem fosters a dialogue about how communities can work together to combat this serious issue.

In their chapter on *Crisis in Older Adults*, Helen DeVries and Suzann Ogland-Hand report on the limited literature regarding working within the geriatric population, concluding that there is little information on crisis management within this population. The authors address the risk for suicide and include a section on alcohol and other substance abuse and cognitive impairment relevant to this population. This chapter would be extremely useful for a graduate-level course on working with the elderly.

Lata McGinn and Carrie Spindle write about *Disaster Trauma* and the threat of safety to communities and individuals in the aftermath of a disaster. The authors describe how survivors react and often develop PTSD. In their chapter on *Terrorism*, Stevan Hobfoll, Tamar Galai-Gat, Dawn Johnson, and Patricia Watson illuminate the intersections of terrorism, trauma, and crisis. I appreciated their discussion of Critical Incident Stress Debriefings (CISD), citing the utility and challenges this type of debriefing provides. CISD is a cognitive-behavioral informed approach to crisis intervention. It was designed to assist with the emotional processing of traumatic events in a structured way. In this debriefing, participants have

the opportunity to express their feelings and thoughts related to the event, while their experiences are normalized and a plan for handling possible future events is discussed. The authors provide extremely useful information, including accessible tables regarding goals around safety, calming, self and communal efficacy, and positive expectancies.

Joop Meijers's chapter on *Problem Solving and Crisis Intervention* comes toward the end of the book, but should have been included earlier, as a review of these models in the beginning of the book would help guide the reader in the application of the described models. This chapter promotes finding solutions to crises and opens with the concept of conceptualizing a problem as potential for growth.

Laurence Miller approaches *Traumatic Stress Disorders* in his chapter. I especially appreciated his coverage of the evolution of the trauma response and the section on civilian stress. He covers PTSD as a syndrome and fleshes out the various symptoms that comprise the diagnosis, differentiating PTSD from the Acute Stress Response. In addition, he places emphasis on the types of civilian stress responses, which is helpful to individuals working in the public sector, not in a military or veteran capacity. He describes the process of psychotherapy with patients with PTSD and suggestions for applying models to the intervention.

Leon VandeCreek and Samuel Knave cover the extremely important topic of *Legal and Ethical Issues in Crisis Intervention*, highlighting ways of working with various crises and patients and provide a section on risk management. This chapter ties together the multiple voices represented in this text. Another critical chapter highlights self-care, which is imperative when working with this population.



Overall, *Cognitive-Behavioral Strategies in Crisis Intervention* is an inclusive guide to meeting individuals, couples, families, and groups where they are in crisis.

Daphny Ainslie, PsyD, is a psychologist in private practice in Austin, Texas. She recently completed a postdoctoral fellowship at the Department of Veterans Affairs where she worked in the areas of substance abuse and trauma. ■

Division 56 Fellows

Division 56 invites and encourages individuals who have “shown evidence of unusual and outstanding contributions or performance in the field of (trauma) psychology” (APA’s hallmark criterion) to apply for Fellowship status within Division 56. You must be an APA member for one year, and a member of Division 56.

APA members who are not yet Fellows of any APA division must meet APA Fellow criteria, apply for Fellow Status according to APA procedures, and complete the APA forms, all described at <http://www.apa.org/membership/Fellows/index.aspx>. In addition to meeting the APA criteria, applicants must meet Division 56 criteria, listed below.

For Division 56, we expect that the “unusual and outstanding contribution or performance” specified in the APA criteria for Fellow Status be specific to the field of trauma psychology. Two or more of the following may provide evidence of such distinction:

1. Being a pioneer in the recognition and application of trauma psychology.
2. Publishing important publications to the field of trauma psychology.
3. Producing consistently outstanding instructional or training programs that educate the next generation of trauma psychologists or developing important innovations in teaching or education in the field.
4. Demonstrating consistently outstanding clinical work with the traumatized, as recognized by international or national groups through citations, awards, and other methods of recognition.
5. Demonstrating consistently outstanding public service relevant to trauma psychology over many years that might include (a) leadership within Division 56, (b) testimony about trauma psychology before courts and Congressional committees or government commissions, (c) service on review panels (e.g., NIH, NSF), or (d) public education/advocacy.
6. Demonstrating leadership in the area of trauma psychology across science, education, policy, and practice internationally and/or nationally.

All new Fellow applicants must complete the APA forms (accessed through the above link) and submit them to the Division 56 Fellow chair, Laurie Pearlman (lpearlmanphd@comcast.net). Division 56 requires that all Fellow application materials (including recommendations) be submitted by **December 1, 2012**. This time frame will allow our Fellow committee to review all materials, make a recommendation, and forward our recommendation to APA in order to meet the deadline.

If you are a current Fellow in another APA division, please contact Laurie Pearlman for information about how to apply for Fellow status in Division 56.■

The Other Side of Love

Dr. Ani Kalayjian

Love may appear to hurt us,
Only to teach us a positive lesson!

Love may appear to frustrate us,
Only to enhance our potential!

Love may appear to anger us,
Only to guide us to inner peace!

Love may appear to restrict us,
Only to show us the way to expansion...

Love may appear to change others even us,
Only to motivate us to grow!

Love may appear to fail us,
Only to make us resilient!

Love may appear to dominate us,
Only to help us set ourselves free!

Love may feel like it's choking us,
Only to encourage our release!

Love may appear to possess us,
Only to show us how to be secure within!

Love may appear blind,
Only to awaken our insight!

Love, as we know it, may appear to end,
Only to help us develop true unconditional love...

Object of love is to serve, not to win (Woodrow Wilson),
so let's stop the race and embrace...



Dr. Anie Kalayjian

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Presidential Voice: Onward to Orlando

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PRESIDENTIAL VOICE

attention internationally. I'm so deeply pleased that these two individuals accepted our invitation to present for us.

I'd like to highlight another symposium that addresses an important and timely topic: the interaction of mTBI and PTSD. These are key wounds of the current wars for the United States, and the group assembled to present on Sunday at 11AM-1PM represents some of the most cutting edge research in the nation. Headed by esteemed neuropsychologists Regina McGlinchey and Bill Milberg (Harvard Medical School), this interdisciplinary symposium also features information on chronic traumatic encephalopathy (CTE) presented by Ann McKee, a pathologist from Boston University School of Medicine, who made the initial observation in the brains of both young and old athletes and combatants. The symposium promises to highlight the impact of these war zone deployments from the physiology to behavior. Jennifer Vasterling (VA Boston), winner of our Outstanding Scientific Achievement Award in 2009, will be the discussant.

A symposium on dissemination efforts for evidence-based trauma treatments is headed by Antonette Zeiss, the first woman and the first psychologist to head the Office of Mental Health in the Department of Veterans Affairs. She will be accompanied on the panel by Nancy Bernardy (Dartmouth), Edna Foa (University of Pennsylvania), and Robin Walser (National Center for PTSD–Palo Alto).

Constance Dalenberg and Bethany Brand will update us on the issue of dissociation and its relationship to trauma, highlighting the possible inclusion of a sub-type of dissociation to be included as a component of the PTSD diagnosis in the DSM-5. Steve Gold (Nova University) will be the discussant of this set of presentations.

Sylvia Marotta will head an international team of speakers in a treatment symposium on interpersonal violence (IPV). This presentation will include domestic violence in Latina women, violence exposure among refugees, and terrorism as experienced by the population in Madrid, Spain. This is, again, cutting edge information on the management of trauma on a scale we rarely consider as psychologists.

Similarly, Richard Tedeschi (University of North Carolina–Charlotte) will head a symposium on

post-traumatic growth across cultural, linguistic, and geographic boundaries. With speakers from Japan, the Ivory Coast, and Turkey, this symposium promises to be a simply outstanding update on the various trajectories of individuals exposed to trauma on a massive scale.

Many other papers, presentations, and symposia highlight the offerings to the APA meetings from Division 56. We worked hard to also code-share with other Divisions in the interest of supporting topics on psychological trauma and in some cases sharing presentation hours to increase what we might offer. All in all, this will prove to be a simply terrific educational experience for our members. Congratulations to our leaders (Sylvia, Denise, and Carlos) and to the many, many reviewers who ably assisted in the process.

Suite Programming: Next, I want to highlight for all of you that we have an incredible set of offerings that will occur in our Suite. For the first time, the Division of Trauma Psychology will be hosting workshops for our membership on topics of great importance. Please consider attending these: forensics in trauma (Dawn Hughes & Constance Dalenberg); identifying and submitting grants for trauma work; (Brian Marx, Ron Acierno, & Diane Castillo); publishing your work in trauma journals (Steve Gold, Sherry Hamby, & Bob Geffner); managing a private practice with a focus on trauma (Lisa Rocchio, Laura Brown, & Sylvia Marotta); and self-care for clinicians involved in trauma work (Charles Figley & Chris Courtois). Please note when these workshops are to be held; this will be a far more intimate experience with these important figures in Trauma Psychology and they're not to be missed.

Official Meetings: Do remember that the Executive Committee meeting is scheduled for Wednesday, August 1 from 4 to 8 PM in the Peabody Hotel (Suite number to be announced). Our Business Meeting will be Friday, August 3 from 5 to 6 PM in the Convention Center (W308B). Our Social Hour/Awards Ceremony will also be Friday evening at 8 PM in the Peabody Grand Ballroom Q.

Please come to Orlando, bring the family, bring a colleague. It will be simply a great time professionally and socially. The presentations promise to be outstanding ones and I look forward to hosting you and the Division at this most important time in the life of our Division. Make your plans now!■

Plan to Attend!
APA Convention
August 2-5, 2012
Orlando, Florida



The Division of Trauma Psychology-Your Home in APA

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.

Why join Division 56?

If you do research on any aspect of traumatic stress, join to further develop the growth of the scientific basis of the field and to meet other professionals working in trauma psychology.

If you work with survivors of trauma, join to become part of the conversation about treatment and research on intervention, and to meet other professionals working in trauma psychology.

If you teach a course on trauma, join to meet colleagues and develop and learn the cutting-edge research and literature for your classes.

If you work on trauma related public policy, join to make sure the expertise of trauma experts is brought to bear on the tough issues APA takes on.

Member Benefits

- Members keep up-to-date on the latest developments in trauma psychology.
- E-newsletters with timely information on traumatic stress are delivered directly to your in-box
- Member-only listserv provides on-going communication with other members and breaking news of trauma-related developments in APA.
- Voting privileges to elect representatives and participation in the Division's annual meetings.
- Eligibility to run for office, chair, and serve on Division committees and task forces.
- Our journal, *Trauma Psychology: Theory, Research, Practice*, Policy at the member rate of 20.00 per year. You do not need to separately subscribe to receive this journal; just be sure that your dues are paid, and your mailing address is up to date.
- 30% discounts on Haworth/Taylor & Francis journals in the field of trauma. To receive these discounts, contact Haworth directly at 1-800-429-6784 (607-722-5857 outside US/Canada) or order on-line and provide the code # TPD20.

Membership Categories

Membership in Division 56 is open to individuals who are not members of APA, in the Professional Affiliate Category. Current students who are APAGS members receive their first year of membership for free, with the option to pay 20.00 to receive the division's journal. Non-APAGS students, and continuing student members, pay a low 10.00 fee, with the option to receive the journal for 20.00. Early career psychologists (ECP) within seven years of receiving their doctorate are eligible for a special rate of 35.00, which includes the journal. APA Associates, Members, and Fellows dues are 45.00, which includes the division journal.

Join Division 56 Now!

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TRAUMA PSYCHOLOGY NEWSLETTER

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