WINTER 2013 • VOL. 8, NO. 1

DIVISION 56

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

NEWSLETTER

A View Inside

Presidential Voice

We Have Come a Long Way and Have Much to Offer

Constance Dalenberg, PhD

In many senses, I continue to be amazed that the Division of Trauma Psychology has managed to fight its way into existence. As a graduate student of psychology at the University of Denver in the 1970's, I was told that sexual abuse of children (and incest in particular) was a rare event, occurring with a prevalence of less than one in one million. Further, one needn't spend much time on issues of disclosure, treatment, or diagnosis because perpetrators would be extreme and obvious psychopaths, and victims would be hovering on the edge of psychosis. The issues and the major players would be obvious and the damage done would be ubiquitous and irreversible. Physical abuse, prior to the publication of the battered child syndrome description in 1962, was also rarely addressed in graduate training, in part because it was allegedly rarely experienced. The term PTSD, posttraumatic stress disorder, grew out of a working group of the Committee on Reactive Disorders, and entered the Diagnostic and Statistical of Mental Disorders III in 1980; therefore, my cohort was learning from those with little experience in the disorder. As a graduate student, I watched the field of trauma psychology grow around me. The change in the degree of complexity and care that are now accorded to the victims of trauma compared to those early times is phenomenal. We have come a long way, and I am proud to see around me now, as a member of Division 56, so many of the people who produced and nurtured that complexity.

Constance Dalenberg, PhD

Although the trauma diagnoses are young, trauma itself has been with us always, and our treatment of the wounded among us defines us as a profession and as a people. Our growth as a field has been reliant on the interplay of clinical and experimental sources. I have lived on that bridge my whole

continued on p. 3

2013 EXECUTIVE COMMITTEE

Officers

President
Constance Dalenberg, PhD
Alliant International University
Email: cdalenberg2@alliant.edu

Past President
Terry Keane, PhD
VA Boston Healthcare System
Email: terry.keane@va.gov

President Elect
Kathleen Kendall-Tackett, PhD, IBCLC
Texas Tech University School of Medicine
Email: kkendallt@aol.com

Secretary
Amber N. Douglas, PhD
Mt. Holyoke College
Email: adouglas@mtholyoke.edu

Treasurer
Beth N. Rom-Rymer, PhD
President, Rom-Rymer and Associates
Email: docbnrr@aol.com

Members-at-Large
Christine Dunning, PhD
University of Wisconsin, Milwaukee
Email: cdunning@uwm.edu

Dawn M. Hughes, PhD
Email: hughes@drdawnhughes.com

Sylvia A. Marotta, PhD, ABPP
The George Washington University
Email: syl@gwu.edu

Council Representatives APA
Joan M. Cook, PhD
Yale University School of Medicine
Email: Joan.Cook@yale.edu

Sandra Mattar, PsyD
Saint Mary's College
Email: sm26@stmarys-ca.edu

Early Career Psychologist Representative
Lesia M. Ruglass, PhD
The City College of New York
Email: lmr2146@columbia.edu

Journal Editor
Psychological Trauma: Theory, Research, Practice, and Policy
Steven N. Gold, PhD
Nova Southeastern University
Email: gold@nova.edu

Professional Affiliate Representative
Irene Sullivan, JD
Email: irenesullivan36@tampabay.rr.com

Student Representative
Jessica Punzo, BS, MA
Email: jpunzo@my.adler.edu

Standing Committees

Awards Committee
Elana Newman, PhD, Chair
University of Tulsa
Email: elana-newman@utulsa.edu

Committee on Collaborative Endeavors
Constance Dalenberg, PhD, Chair
Alliant International University
Email: cdalenberg2@alliant.edu

Disaster Relief Committee
Gilbert Reyes, PhD, Chair
Fielding Graduate University
Email: greyes@fielding.edu

Diversity and Multicultural Committee
Sylvia A. Marotta, PhD, ABPP, Chair
The George Washington University
Email: syl@gwu.edu

Early Career Psychologists Committee
Lesia M. Ruglass, PhD, Chair
The City College of New York
Email: lmr2146@columbia.edu

Education and Training Committee
Elana Newman, PhD, Chair
University of Tulsa
Email: elana-newman@utulsa.edu

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

Finance Committee
Beth N. Rom-Rymer, PhD, Chair
President, Rom-Rymer and Associates
Email: docbnrr@gmail.com

International Committee
Elizabeth Carll, PhD, Chair
Email: drcarll@optonline.net

Liaison Committee
Catherine C. Classen, PhD, CPsych, Chair
Women's College Hospital
Email: catherine.classen@wchospital.edu

Membership Committee
Lisa Rocchio, PhD, Chair
Email: lrocchio@cox.net

Nominations and Election Committee
Terry Keane, PhD, Chair
VA Boston Healthcare System & Boston University
Email: terry.keane@va.gov

Policy Committee
Diane Elmore, PhD, MPH, Chair
American Psychological Association
Email: delmore@apa.org

Practice Committee
Bethany Brand, PhD, Chair
Towson University
Email: bbrand@towson.edu

Program Committee
Denise Sloan, PhD, Co-Chair
National Center for PTSD, Behavioral Science Division
Email: denise.sloan@va.gov

Carlos Cuevas, PhD , Co-Chair
Northeastern University
Email: c.cuevas@neu.edu

Publications Committee
Christine Courtois, PhD, Chair
Christine A. Courtois, PhD & Associates, PLC
Email: CACourtoisPhD@aol.com

Science Committee
Brian Marx, PhD, Chair
National Center for PTSD
Email: brian.marx@va.gov

Special Interest Groups
Stacey Seibel, PhD, Chair
Park Nicollet Clinic: Sexual Health
Email: stacey.seibel@parknicollet.com

Student Affairs Committee
Jessica Punzo, BS, MA, Chair
Email: jpunzo@my.adler.edu

Newsletter Editor
TRAUMA PSYCHOLOGY NEWSLETTER
Simon A. Rego, PsyD, ABPP, ACT
Montefiore Medical Center
Email: srego@montefiore.org

Associate Editor
Renu Aldrich, MFTi
Hofstra University
Email: renu@renualdrich.com

Web Editor
www.apatraumadivision.org
Tyson Bailey, PsyD
Email: tdbaileypsyd@gmail.com

Listserv Manager
M. Rose Barlow, PhD
Boise State University
Email: rosebarlow@boisestate.edu

Task Forces

Diversity Issues Task Force
Priscilla Dass-Brailsford, EdD, CTS, Co-Chair
Georgetown University Hospital
Email: pd227@georgetown.edu

Sandra Mattar, PsyD, Co-Chair
Saint Mary's College
Email: sm26@stmarys-ca.edu

Task Force on the Assessment of Trauma Sequelae
Judith Armstrong, PhD, Chair
Email: jarmstro@usc.edu

Ethical Issues in Forensic Cases Involving Trauma and Abuse Issues Task Force
Philip J. Kinsler, PhD, Co-Chair
Dartmouth Medical School
Email: psyfil@earthlink.net

Beth N. Rom-Rymer, PhD, Co-Chair
President, Rom-Rymer and Associates
Email: docbnrr@gmail.com

Task Force on Trauma Psychology and Social Justice
Amber Douglas, PhD, Chair
Mt Holyoke College
Email: douglasambern@gmail.com

Division 56 Member Services

Join Division 56: www.apa.org/divapp

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

Membership Term: Membership is for January-December. If you apply during August-December, your membership will be applied to the following January-December.

Website: www.apatraumadivision.org

Listservs: Everyone is added to the announce listserv, div56announce@lists.apa.org (where news and announcements are sent out; membership in Division 56 is required). To join the discussion listserv, div56@lists.apa.org (where discussion happens; membership is not required), send a note to listserv@lists.apa.org and type the following in the body of the note: subscribe div56

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

Newsletter: The newsletter is sent out on the announce listserv and is available on the website.

Membership Issues: Contact Keith Cooke at kcooke@apa.org.

Presidential Voice

continued from p. 1

life, and I hope that further integration of these facets of our field will be one of my legacies. I am a long-time clinician, and teacher of trauma treatment, but also a long-time professor of multivariate statistics. My love of mathematics and statistical theory is the older of my two vocations. In fact, I vividly remember being called into the office of my high school when I signed up to take Trigonometry in high school. A counselor or assistant principal kindly explained to me that I was the only girl who had signed up, and that I would be a social outcast if I insisted on taking the course, hinting broadly that boys of my age group looked askance at girls who were interested in Trigonometry.

This is where an account by a different author would be a bit more inspiring. I'd like to tell you that I leaped on a table like a young Norma Rae and demanded my right to take Trigonometry, social ostracism be damned! What actually happened was that I thanked the AP profusely for protecting my social life, checked out the Trig book from the library, and learned it on my own. It was not until college, when I signed up for a math course with Trigonometry as a pre-requisite (and was discovered given my rather unique self-taught methods of solving certain problems), that a more open-minded professor suggested that I might have an aptitude that could be useful. Since then I have been both math and psychology major, both doctoral candidate and PhD in social/experimental and clinical psychology, and both the researcher and clinician. But then so, in various ratios, are you. You are a clinician who must stay current on the literature and be aware enough of psychometrics to interpret tests and sift the wheat from the chaff of the burgeoning literature. Or you are a researcher who is trying to contribute practically to the field and must know something of psychopathology, psychotherapy, and psychodynamics to do so. It's a busy life, isn't it?

The issue then is how do we do it? How do we find the time to critically analyze the literature AND treat our patients? The place we are trying to build here is one answer to that question, and I am trying to expand on the work of prior Presidents and Division 56 members to make the latest research and the latest clinical findings and innovations more accessible to all of us. One place to find these connections is the Division 56 program at the APA Convention—this year in Hawaii (July 31 to August 4). Thanks to the hard work of our program co-chairs, Denise Sloan and Carlos Cuevas, we have an amazing program. For instance, among our many offerings, you could choose from some of the following talks:

- John Briere, one of the most well-respected trauma psychologists in the country, speaking about mindfulness and the treatment of trauma
- Past President of Division 56, Terry Keane, discussing improving assessment and treatment of veterans (note also that the Presidential initiative on support to military personnel and their families will offer 20-30 hours of programming)
- George Bonanno, brilliant theoretician and fascinating speaker, discussing his work on regulatory flexibility as a resilience factor after trauma
- Jill Stoddard, Director of Stress and Anxiety Management in San Diego, introducing new metaphors and findings for practitioners of Acceptance Commitment Therapy
- A symposium featuring Lori Zoellner, Steven Thorp, and Michael de Arellano on innovations in cognitive treatment of trauma, including enhancing the effectiveness of exposure therapy and use of technology-facilitated therapy with adults and children
- Joan Cook, one of Division 56's representatives to APA's Council of Representatives, speaking about the new consensus on trauma training competencies, which will be developed during the April 2013 conference
- Numerous specialized symposia on forensic issues in trauma psychology, co-sponsored by Division 56 and Division 41 (Law and Psychology)
- A specialized presentation on dozens of available apps useful to the trauma psychologist, including a talk by Joe Rusek on the PTSD coach application
- Phil Zimbardo, one of APA's most popular and most inspiring teachers and researchers, discussing the relevance of time perspective to the treatment of trauma
- Watch your mailboxes also for information about our workshop in how to add heart rate biofeedback to your trauma practice, including information and training on use of low-cost equipment and home systems for your patients. This training can cost hundreds of dollars elsewhere, but will be available by appointment free to members of Division 56 (from 2:00 to 4:00 in the Division 56 Suite; official APA programming will occur only until 2 pm each day, leaving you time to enjoy Hawaii).

Another initiative that I am proposing this year, again addressing the science-practitioner bridge, is a committee on Trauma Response. This committee will supervise the development of Trauma FAQs and White Papers that will be available to the public assembling teams of top researchers and clinicians. Over time, we would like to develop an archive of the latest clinical and research thought on response to specific traumas and disasters. Division 56 could be the place that community

psychologists could go after a devastating fire, workplace explosion, or gun-related violence incident, as well as a place for the individual clinician treating a torture, rape, incest, bullying, or assault victim. The FAQs could and will include information about services that communities should set up, advice about talking to children about the disasters, and links to specialized information on each topic. The White Papers that are in process are the Trauma Assessment Guidelines, chaired by Judith Armstrong, and the Complex Trauma Treatment Guidelines, chaired by Christine Courtois. The Trauma Response Committee will also constitute a committee on Trauma Memory to update the APA findings on the topic from 1996. The first FAQ, focused on response to fire, will be chaired by Russell Johnson, nationally known expert on fire-related injury and trauma.

Nonetheless, we have challenges ahead of us. I come to this office two weeks after the second deadliest shooting in United States history, where 28 victims died (including 20 children). We have much to contribute and much to learn about addressing the wounds of a community such as Sandy Hook, including advice about making practical decisions. (How do we talk to our children about these events? Was it positive or negative to rename the new school after the old one, to bring in the original furniture, to wait a few weeks before returning the children to school?) APA members as a whole are talking about taking a position on gun violence. How does Division 56 choose to play a part in these efforts? I hope that the Trauma Response committee will play a positive role in providing directions for healing after tragedy in the future, but we may wish to take other steps.

We plan on continuing many of the traditions that have built Division 56, including supporting the Multicultural Summit for Psychology, supporting the travel of our Early Career Psychologist representatives, and facilitating the travel of an international student. Joan Cook and Elana Newman will be bringing their long-planned conference on trauma training competencies to fruition in April. Steve Frankel has agreed to chair our new Governance Committee, which will put the final touches on our bylaws and procedures, much of which has been the work of Laura Brown and Kathy Kendall-Tackett, our President-Elect.

Finally, I am exceedingly grateful to the current Executive Council and the greater membership of Division 56 for giving me an opportunity to make any contribution that I can to this wonderful organization. Laura Brown and Chris Courtois have been heroines for me for many years and Steve Gold, through his phenomenal stewardship of our journal, *Psychological Trauma,* as well as simply through his friendship, has been a powerful positive force in my professional and personal life. Working with Terry Keane, our Past President, has taught me a good deal about effective administration and leadership, as I can tell will be true of our future president, Kathy Kendall-Tackett. I am also amazed at what Simon Rego has done with this newsletter and what Lynn Brem and now Tyson Bailey have managed to create for our website. Please contact me if you have ideas for our future, if you want to be part of the Division leadership, or if you have comments about our past and future programming. See you in Hawaii!!!■

To the Editor

Re: The "best interest" standard versus changing the standard to assure child safety.

I appreciate Toby Kleinman's (2012) concern that abused children are being systematically and routinely given to known abusers for unsupervised visits and placed in their custody. This is a major national controversy (Walker, Cummings, & Cummings, 2012) that has been flying under the radar for too long.

Attorney Kleinman was generous in describing psychologists who participate in securing the abuser's access to his child victims as "untrained." Many such psychologists may indeed lack the necessary specialized training in trauma, domestic violence, and child abuse; however, others are highly qualified, know exactly what they are doing, and influence the system on behalf of their perpetrator clients.

When a few psychologists were discovered to have been participating in torture in military or intelligence settings, this was, appropriately, cause for years of APA soul-searching, ethics code revisions, and public statements (American Psychological Association, 2012). Yet, today countless psychologists are actively promoting child abuse—whether by incompetence or intent—throughout the country.

It is indisputable that this harm to children is occurring on a widespread basis (Leadership Council, 2008), and incomprehensible that we allow our profession to facilitate this.

RICKY GREENWALD, PsyD
Trauma Institute & Child Trauma Institute, Greenfield, MA

References

American Psychological Association. (2012). *Timeline of APA policies & actions related to detainee welfare and professional ethics in the context of interrogation and national security.* Retrieved from http://www.apa.org/news/press/statements/interrogations.aspx

Kleinman, T. (2012). The "best interest" standard versus changing the standard to assure child safety. *Division 56 Trauma Psychology Newsletter, 7(3),* 5-7.

Leadership Council. (2008). *How many children are court-ordered into unsupervised contact with an abusive parent after divorce?* Retrieved from http://leadershipcouncil.org/1/med/PR3.html

Walker, L. E. A., Cummings, D. M., & Cummings, N. A. (Eds.). (2012). *Our broken family court system*. New York: Ithaca Press.■

Older Women Survivors of Interpersonal Violence Are a Neglected Population: Research, Practice, and Policy Implications

Stephanie Dinnen, MS, and Joan M. Cook, PhD

Interpersonal violence (IPV) is a largely unrecognized reality in the lives of a significant minority of older women. This type of trauma can have deleterious consequences on an older woman's mental as well as physical health (e.g., Fisher, Zink, & Regan, 2011). However, unlike attention paid to younger and middle-aged women survivors of IPV, public awareness, research, and service provision specifically attenuated to older women is sorely lacking.

Stephanie Dinnen, MS

Joan M. Cook, PhD

Prevalence estimates of IPV in older women range from 6% to 59% over the lifetime, from 6% to 18% since turning 50, and from 0.8% to 11% in the past year (for review, see Cook, Dinnen, & O'Donnell, 2011). These rates are considerably lower compared to younger and middle-aged women (Renison & Rand, 2003). In addition, older women also report lower levels of associated negative psychological IPV consequences than younger women (e.g., Acierno et al., 2002). Nonetheless, older women who report a history of IPV have greater psychological difficulties than older women who do not have these experiences. Using data from a nationally representative sample, one out of seven older women reported a history of physical or sexual assault or both (Cook, Pilver, Dinnen, Schnurr, & Desai, in press). Those who experienced IPV were generally more likely than those without such history to meet criteria for past-year and lifetime Posttraumatic Stress Disorder (PTSD), depression, or anxiety. Thus some women who have been physically or sexually assaulted decades earlier continue to report significant levels of mood and anxiety disorders well into late life.

There are several possible explanations for lower IPV prevalence and associated psychopathology in older compared to younger women. One is that there are cohort-related differences between older, middle-aged, and younger women. For example, older women may not share the same lexicon of younger women and thus may not accurately label and report incidences of IPV. Other potential reporting biases include financial insecurity (e.g., the current cohort of older women are less likely to have participated in the workforce and may therefore be more dependent on a spouse's social security income) or they may have had negative reporting experiences in the past (Zink, Regan, Jacobsen, & Pabst, 2003). Further, the current cohort of older women was socialized at a time when personal matters were not discussed outside the home (Zink et al., 2003). Additionally, due to the passage of time, IPV events that took place earlier in one's life may now be diminished in terms of perceived relevance or significance (Norris, 1992).

Although no older woman had disclosed traumatic experiences at the time of outpatient admission at one of two mental health centers, about 85% disclosed histories of childhood abuse, domestic violence, or both during the course of therapy (Wolkenstein & Sterman, 1998). Additionally, older women are more likely to report somatic, rather than specific mental health complaints, and may not associate these physical symptoms with psychological distress or trauma histories (Mouton, 2003). Thus older women seeking help for depression and anxiety in outpatient mental or medical health settings may have unresolved trauma issues that are contributing to their symptoms and in need of psychological intervention.

Qualitative investigations with primary care physicians suggest reluctance to ask older women about IPV, particularly sexual abuse (Zink et al., 2004). This may be due in part to the misperception that IPV is a younger women's problem. Additional provider barriers to addressing IPV with older women include provider discomfort, concern about patient's ability to acknowledge and effectively

cope with trauma-related issues, and lack of time and training (Zink et al., 2004). Efforts to overcome these obstacles in health care providers include curriculum or continuing education opportunities for providers working with geriatric populations focusing on assessment of IPV as well as risk factors for its occurrence. This is particularly important as a lack of acknowledgment and identification of the effects of IPV in older women can lead to the provision of inappropriate or inadequate psychotherapy, pharmacotherapy, or other medical intervention (Allers, Benjack, & Allers, 1992).

There are few psychometrically sound measures of IPV for older adult women (e.g., Nelson, Nygren, McInery, & Klein, 2004; Paranjape, Rodriguez, Guaghan, & Kaslow, 2009) and none have been evaluated against measurable violence or health outcomes. Although there are several measures of trauma-related psychopathology that have been used with older adults, this work has been done primarily with male veterans (for review, see Cook & O'Donnell, 2005). Thus it is important to recognize the limitations and generalizability of current assessment tools with this population.

To date there are no published randomized controlled trials on the efficacy of psychotherapy for PTSD in older women. One treatment trial of sexual assault survivors with PTSD (age range 18-70, mean 32) found that older women in Prolonged Exposure (Foa, Hembree, & Rothbaum, 2007) and younger women in Cognitive Processing Therapy (Resick & Schnicke, 1993) had the best outcomes (Rizvi, Vogt, & Resick, 2009). The authors suggest that older women in the exposure condition may have responded better due to older adults' potential limited abilities with abstraction and the need to complete numerous written assignments in cognitive therapy. In the absence of randomized controlled trials of psychotherapeutic interventions with older women survivors of IPV, several case studies have demonstrated some success with this population using various treatment modalities including cognitive-behavioral therapy, life review, and supportive psychotherapy (for review see Cook & O'Donnell, 2005).

Current IPV services generally fail to address important needs of older women such as access to medication, handicap accessibility, and legal aid for issues relevant to older age (Vinton, 2003). Practice and policy efforts for agencies providing such services include the provision of part-time or as-needed medical staff to distribute medication and staff to address legal needs that are common among or unique to older women such as assistance with claiming social security, disability benefits, and pensions. Clearly more treatment and services research is needed to address long-standing IPV-related pathology in older women as well as to assist in healing from current abuse.

Relatively little is known about rates of traumatic exposure and the subsequent presentation of mental health effects in older non-Caucasian women. Studies of social service utilization following IPV among older women reveal differences in support-seeking (e.g., legal, emotional, medical) (Baker et al., 2009), as well as rates of abuse across races. Further research is needed to elucidate how ethnicity and culture affects mental health presentation in older IPV survivors and potential culturally specific modifications to assessment and treatment.

In summary, IPV should no longer remain a "hidden variable" (Nichols & Czir, 1998) in the lives of older women. Research is needed to better identify presentation, assessment, and treatment issues with this population. Policy efforts are needed to improve public awareness, and education is needed to inform health care providers how to detect and treat older women IPV survivors with associated psychological consequences.

References

Acierno, R., Brady, K. L., Gray, M., Kilpatrick, D. G., Resnick, H. S., & Best, C. L. (2002). Psychopathology following interpersonal violence: A comparison of risk factors in older and younger adults. *Journal of Clinical Geropsychology, 8,* 13-23.

Allers, C. T., Benjack, K. J., & Allers, N. T. (1992). Unresolved childhood sexual abuse: Are older adults affected? *Journal of Counseling & Development, 71,* 14-17.

Baker, M. W., LaCroiz, A. Z., Chunyuan, W., Cochrane, B. B., Wallace, R., & Woods, N. F. (2009). Mortality risk associated with physical and verbal abuse in women aged 50 to 79. *Journal of the American Geriatric Society, 57,* 1799–1809.

Cook, J. M. & O'Donnell, C. (2005). Assessment and psychological treatment of posttraumatic stress disorder in older adults. *Journal of Geriatric Psychiatry and Neurology*, *18,* 61-71.

Cook, J. M., Dinnen, S. & O'Donnell, C. (2011). Older women survivors of physical and sexual violence: A systematic review of the quantitative literature. *Journal of Women's Health, 20,* 1075-1081.

Cook, J. M., Pilver, C., Dinnen, S., & Desai, R. (E-pub ahead of print). Lifetime prevalence of physical and sexual assault and current mental disorders in older women: Findings from a nationally representative sample. *American Journal Geriatric Psychiatry.*

Fisher, B. S., Zink, T., & Regan, S. L. (2011). Abuse against older women: Prevalence and health effects. *Journal of Interpersonal Violence, 26,* 254-268.

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences therapist guide.* New York: Oxford University Press.

Grossman, S. & Lundy, M. (2003). Use of domestic violence services across race and ethnicity by women 55 and older: The Illinois experience. *Violence Against Women, 12,* 1442–1452.

Mouton, C. P. (2003). Intimate partner violence and health status among older women. *Violence Against Women, 9,* 1465-1477.

Nelson, H. D., Nygren, P., McInerney, Y., & Klein, J. (2004). Screening women and elderly adults for family and intimate partner violence: A review of the evidence for the U.S. Preventive Services Task Force. *Annals of Internal Medicine, 140,* 387-396.

Nichols, B. L., & Czir, R. (1998). Posttraumatic stress disorder: Hidden syndrome in elders. *Clinical Gerontologist, 5,* 417-433.

Norris, F. H. (1992). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Clinical and Consulting Psychology, 60,* 409–418.

Paranjape, A., Rodriguez, M., Gaughan, J., & Kaslow, N. J. (2009). Psychometric properties of a new scale to assess family violence in older African American women: The Family Violence Against Older Women (FVOW) Scale. *Violence Against Women, 15,* 1213–1226.

Renison, C., & Rand, M. R. (2003). Nonlethal intimate partner violence against women: A comparison of three age cohorts. *Violence Against*

Women, 9, 1417-1428.
Resick, P. A., & Schnicke, M. K. (1993). *Cognitive processing therapy for rape victims: A treatment manual.* Newbury Park, CA: Sage Publications.
Rizvi, S. L., Vogt, D. S., & Resick, P. A. (2009). Cognitive and affective predictors of treatment outcome in Cognitive Processing Therapy and Prolonged Exposure for posttraumatic stress disorder. *Behaviour Research and Therapy, 47*, 737-743.
Vinton, L. (2003). A model collaborative project toward making domestic violence centers elder ready. *Violence Against Women, 12,* 1504-1513.
Wolkenstein, B. H., & Sterman, L. (1998). Unmet needs of older women in a clinical population: The discovery of possible long-term sequelae of domestic violence. *Professional Psychology: Research and Practice, 29,* 341-348.
Zink, T., Regan, S., Jacobson, J., & Pabst, S. (2003). Cohort, period and aging effects: A qualitative study of older women's reasons for remaining in abusive relationships. *Violence Against Women, 9,* 1429–1441.
Zink, T., Regan, S., Goldenhar, L., Pabst, S., & Rinto, B. (2004). Intimate partner violence: Physicians' experiences with women over 55. *Journal of the American Board of Family Practitioners, 17,* 332-340.

Stephanie Dinnen *is a Research Associate at Yale School of Medicine, Department of Psychiatry. She received her Master of Science degree in Gerontology from the University of Massachusetts at Boston. Her main areas of interest are interpersonal violence in later life and trauma mental health across the life span.*

Joan Cook *is an Associate Professor in the Yale School of Medicine, Department of Psychiatry and is a researcher at the National Center for PTSD. She has numerous publications in the traumatic stress and geriatric mental health fields, including scientific papers on the phenomenology, assessment, and treatment of older adult trauma survivors. She is currently funded by the National Institute of Mental Health to study the dissemination and implementation of effective mental health services for PTSD.*

FEATURED ARTICLE

"I Want To Be a Better Father": Case Studies From Downrange

CPT Tim Hoyt, PhD
2nd Stryker Brigade Combat Team, 2nd Infantry Division, United States Army, Kandahar, Afghanistan

In my role as a deployed psychologist with an Army Infantry Brigade at a Forward Operating Base in Afghanistan, I have primary responsibility for maintaining the psychological health of over four thousand soldiers. In my role as a father, I work on maintaining relationships with my four girls, who understand that "daddy helps the soldiers when they have bad dreams." These roles have recently come together as many service members here identify a desire to become a better parent as an important treatment goal.

CPT Tim Hoyt, PhD

A significant body of literature has examined the effects of deployments on families (Pincus, Leiner, Black, & Singh, 2011). Children in military families are at greater risk for emotional and behavioral problems (Chandra et al., 2010), and these problems may be exacerbated during deployment (Gorman, Eide, & Hisle-Gorman, 2010). The effects of deployment on fathers, particularly symptoms of posttraumatic stress, also can have an impact on their subsequent parenting relationships (Ruscio, Weathers, King, & King, 2002; Samper, Taft, King, & King, 2004). Even in areas where combat trauma would ostensibly be the greatest psychological threat to soldiers, family and relationship concerns can make up a majority of presenting complaints (Moore & Reger, 2006). Indeed, over 30% of psychiatric medical evacuations in our brigade are related to family concerns.

Previous research indicates that deployed fathers experience concern about still playing a role in the family, motivation to remain involved in their children's lives, worry regarding who will raise their children if they are killed, guilt over being an absent father, and remorse for losing opportunities to parent while deployed (Schachman, 2010; Willerton, Schwarz, MacDermid Wadsworth, & Oglesby, 2011). However, the literature on deployed parenting often focuses on pre- and post-deployment settings rather than intervention during deployment, likely because only minimal intervention may be possible while in a combat zone (Huebner, Mancini, Wilcox, Grass, & Grass, 2007; Wilson, Wilkum, Chernichky, MacDermid Wadsworth, & Broniarczyk, 2011). In the context of deployment, these parenting concerns were addressed through maximizing dedicated parent-child contact. Direct interactions can be significantly limited, ranging from daily contact via webcam or social network sites to

weekly contact via telephone, with sessions spanning no longer than ten minutes.

Case 1

Sergeant First Class (SFC) Delta was a 38 year-old active duty information systems operator on his fourth tour. He presented to the behavioral health clinic after several problematic interactions with his 14-year-old son, who received failing grades and was suspended from the football team. This resulted in arguments between father and son about "taking school seriously" and the cost of sports participation. SFC Delta explained during therapy sessions that he was "already done" with his son, and was simply waiting until the son turned 18 to get him out of the house. Intervention in this case focused on helping the father take the son's perspective, including encouraging the service member to view his son as one of his soldiers. Enlisted service members undergo monthly developmental counseling, in which progress and goals are reviewed and constructive corrections can be made. By seeing the problem from this perspective, SFC Delta realized that his son's coach and teammates already expressed disappointment in him. SFC Delta was then able to restructure subsequent conversations with his son to focus on supporting and listening to his son, in the same way he would develop his soldiers. SFC Delta came to view himself as a mentor during a difficult time, rather than seeing his son's behavior as a "merit badge." After approximately one month of weekly, 10-minute mentoring interactions, the son improved his grades and was able to rejoin the football team.

Case 2

Staff Sergeant (SSG) Bravo was a 41-year-old active duty artilleryman already enrolled in care for PTSD symptoms related to a prior deployment. On his daughter's 16th birthday, she became irate, citing stress that her father missed her birthday and that she missed him. This resulted in arguments between the daughter and the spouse of the service member due to the teen's behavior, as well as subsequent arguments between the service member and his spouse regarding how the mother handled the situation. Service members are very familiar with the "eighty percent solution"—a battlefield decision made under time pressure with only limited resources. Based on this framework, SSG Bravo recognized that "whatever my wife did [with my daughter] was the right answer at the time." SSG Bravo then arranged for a second birthday celebration with his daughter, planned for his mid-tour leave. For the next several weeks, interactions between father and daughter centered on planning what they would do together, which provided a context for discussions between them. SSG Bravo's spouse also reported that the daughter's behavior improved significantly.

Case 3

Sergeant (SGT) Echo was a 25-year-old active duty infantryman who presented to the clinic with depression symptoms a few weeks after being notified that his 8-year-old daughter was molested by a neighbor. In addition to anger regarding what happened to his daughter, SGT Echo also experienced a recurrence of posttraumatic stress symptoms related to his own abuse history. SGT Echo's difficulties may exemplify how electronic communication has increased contact between children and deployed parents (Mmari et al., 2009) but how overreliance on email and social media may create new challenges. Indeed, other deployed fathers have expressed that they must have distance from the lives of their children, as over-involvement will distract them from their primary mission (Willerton et al., 2011). Communication through instant messaging was a means of avoidance for SGT Echo, who felt telephone contact would overwhelm him with feelings of anger and memories of his past. Nonetheless, he felt he was "a bad parent" for not providing enough support for his daughter. The provider worked with SGT Echo to establish dedicated time for his daughter by calling (rather than instant messaging), and allowing her to guide the conversation, talk about school or friends, and ask questions regarding her father's deployment. These talks also provided a form of exposure to anxiety provoking situations that helped reduce SGT Echo's posttraumatic stress symptoms.

These cases provide a number of lessons for future intervention with deployed fathers. The first step in each case was establishing regular contact. Even with the greater availability of communication for deployed service members, these fathers did not maintain regular contact with their children before addressing their concerns in therapy. Often, this first step involved challenging the belief that "nothing will change until I am home." These fathers also seemed to believe that no immediate solution was needed for their children's behavior problems, in contrast to the demand for urgent problem solving on the battlefield. Once these deployed fathers recognized that although the ultimate outcome would take time, their efforts while deployed were still valuable, they were more willing to engage with their children and make progress. Finally, finding opportunities to learn that their children were proud of them provided additional motivation for these service members to strengthen family bonds, despite the distance caused by their selfless service to their country.

References

Chandra, A., Lara-Cinisomo, S., Jaycox, L., Tanielian, T., Burns, R., Ruder, T., & Han, B. (2010). Children on the homefront: The experience of children from military families. *Pediatrics, 125*, 16-15.

Gorman, G., Eide, M., & Hisle-Gorman, E. (2010). Wartime military deployment and increased pediatric mental and behavioral health complaints. *Pediatrics, 126*, 1058-1066.

Mmari, K., Roche, K., Sudhinaraset, M., & Blum, R. (2009). When a parent goes off to war: Exploring the issues faced by adolescents and their families. *Youth & Society, 40*, 455-475.
Moore, B., & Reger, G. (2006). Clinician to frontline soldier: A look at the roles and challenges of Army clinical psychologists in Iraq. *Journal of Clinical Psychology, 62*, 395-403.
Pincus, S., Leiner, B., Black, N., & Singh, T. (2011). The impact of deployment on military families and children. In E. C. Ritchie (Ed.), *Combat and operational behavioral health* (pp. 487-501). Falls Church, VA: Office of the Surgeon General, United States Army.
Ruscio, A., Weathers, F., King, L., & King, D. Male war-zone veterans' perceived relationships with their children: The importance of emotional numbing. *Journal of Traumatic Stress, 15*, 351–357.
Samper, R., Taft, C., King, D., & King, L. (2004). Posttraumatic stress disorder symptoms and parenting satisfaction among a national sample of male Vietnam veterans. *Journal of Traumatic Stress, 17*, 311–315.
Schachman, K. (2010). Online fathering: The experience of first-time deployed fatherhood in combat-deployed troops. *Nursing Research, 59*, 11-17.
Willerton, E., Schwarz, R., MacDermid Wadsworth, S., & Oglesby, M. (2011). Military fathers' perspectives on involvement. *Journal of Family Psychology, 25*, 521-530.
Wilson, S., Wilkum, K., Chernichky, S., MacDermid Wadsworth, S., & Broniarczyk, K. (2011). Passport Toward Success: Description and evaluation of a program designed to help children and families reconnect after a military deployment. *Journal of Applied Communication Research, 39*, 223-249.

***Tim Hoyt** is a Captain in the Medical Service Corps of the United States Army, currently serving as the Officer in Charge of Behavioral Health for the 2nd Stryker Brigade Combat Team, 2nd Infantry Division. His research focuses on the way soldiers share combat stories with others, as well as personality profiles associated with PTSD development. He received his PhD in Clinical Psychology from the University of New Mexico.*

APA Practice Directorate Offers Several Tools to Help Practitioners

As most APA members know, the APA's Practice Directorate promotes the practice of psychology—and the accessibility and availability of psychological services—through legislative and judicial advocacy, public education, and marketplace initiatives. However, in addition to these broader activities geared toward advancing psychological practice, the Practice Directorate also provides free access to resources that APA members can use in their daily activities. Two resources that practitioners might find particularly useful are PracticeOUTCOMES: Measures for Psychologists and PsycLINK: The Practice Wiki.

PracticeOUTCOMES: Measures for Psychologists is a relational database designed for practicing psychologists to search for complete information about a range of outcome measures suitable for professional practice. Tools within the database are intended to be used for screening, diagnostic, and outcome measurement purposes. As demand for outcome measurement proliferates across the health care landscape, psychologists, by training, are well-equipped to spearhead the implementation of such measurement within systems of care. The PracticeOUTCOMES database is fairly new and still growing as it contains about 100 measures; members are encouraged to submit or recommend a measure in order to add to its utility.

PsycLINK: The Practice Wiki, is a free electronic resource that has been available to members for several years. Recently, however, its contents and platform have migrated to APA's "Communities" tool, resulting in a more versatile and user-friendly experience. PsycLINK is a social-business communications experience built into APA Communities that allows users (i.e., using their "My APA" login credentials) to share and post content that they find germane to professional practice. Features that facilitate this process within PsycLINK include the creation of person blogs to share and elicit opinions; polls, to gather quantifiable information about others' experience as practitioners; and project management capabilities, to allow professional collaboration in real-time, and more.

To access PracticeOUTCOMES, members should direct their browsers to the following URL: http://practiceoutcomes.apa.org. To access PsycLINK, members should go to http://www.apacommunities.org and click on "PsycLINK" under the "spaces" toolbar on the APA Communities dashboard. Both resources utilize "MyAPA" login credentials and are free to members.

—Nathan A. Tatro, MA
Project Manager, Practice Research & Policy
Practice Directorate

Domestic Violence and Child Protection: Is What We Are Doing Working?

Toby Kleinman, Esq.

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.

I have been writing law journal articles, legal columns, editorials and op-eds, and giving keynote addresses for many years on the issue of domestic violence and child protection. I have trained judges and given workshops to professionals. I look forward to writing and speaking. But before writing this column, I asked myself, "Is what we are doing working? And who are 'we'?" I stumped myself because I had no answer. I became distressed as I realized my first response was that it is NOT working, as kids continue to be abused and courts still send abused children to their molesters (Saunders et al., 2011).

Toby Kleinman, Esq.

As I dug a little deeper, I tried to identify specific issues and assess in a more positive way. What I came up with was a series of questions:

- How should I measure success?
- How do I know if what we are doing is working?
- Are more children safe?
- Are more battered women able to protect their children?
- Are the courts more sensitive now than they were 10 years ago? 5 years ago?
- Are more lawyers familiarizing themselves with the impact of DV on children?
- Are more psychologists/evaluators better able to assess the impact of violence on children and render opinions to courts that give the courts the information they need to protect children?

Sadly, quick answers to those questions were also a resounding no. However, I didn't let it go. There were other questions and other things to ponder. I began a retrospective examination of my own work.

I began doing domestic violence work as a member of a board of a battered women's shelter in 1980. I felt isolated. There was no one to talk to. Now I have a community comprised of many organizations whose members I can speak with, whose work I read, and who provide research and expertise to lawyers, judges, and mental health professionals. That community is comprised of law school domestic violence clinics, and the national network of DV LEAP (Domestic Violence and Legal Empowerment and Appeals Project), run by Joan Meier, which empowers women by filing free appeals, appeals that can and do change what trial judges do.

My community is Eileen King, formerly of Justice for Children, who, when all else seems to fail, helps many women find pro bono attorneys. My community is the Battered Mothers Custody Conference, which brings experts, lawyers, and battered mothers together each year and invites me to talk. It includes Garland Waller, who creates magnificent documentaries that educate the public and tell stories of the failures of the court system and how it needs to change. My community is Division 56, Trauma Psychology, and all of you who read this column and think a little more about what to do to protect our children. It is the children who need us all. So as I pondered, I revised my answer to, "Yes, it is working." There are communities all over the country trying to educate the courts and protect women and children. The Violence Against Women Act (VAWA) gives national recognition to the importance of protecting women from violence in the home. All of these people and organizations and legislators are the "we," the community that acts to protect children. I call this success.

Indeed, the measurement of success is complex. In a courtroom, these issues regularly fall back to the question of parental rights versus safety of a child in a contested matrimonial forum. Since an abuser is often more financially capable of driving and surviving the litigation, what can a protective parent do to seek child protection? I have a mantra I tell every protective parent I represent, "You need to find the power you have and then learn to use it effectively." The community that thinks about this issue and attempts to help is the power protective parents have and the power they are using. They are meeting and sharing experiences. There are listservs and blogs. We are researching, listening, reading, and learning and we, who care, are growing in numbers.

We are still facing the difficult challenges of litigation, the bias of the community, amid the refusal

of many to integrate what is known about stranger violence with family violence. The old and romanticized notions of fathers who injure their families but claim to want to spend more time with their children is becoming understood as a misuse of power. While many laws on the books are still not properly implemented, and junk science concepts such as parent alienation still run rampant in many jurisdictions, we are seeing changes being made.

Too often I still see a "trip point" in child protection litigation, where the court reaches an all too common threshold, and its focus changes from child protection to the parental rights of the litigants. As the matter proceeds, it appears the protective parent then becomes labeled as the "uncooperative parent." But, protective parents are stronger today than yesterday. Many changes in the courts have taken place. Many still face the challenges of losing children to abusers, and many are still embattled in unfair family courts. Nevertheless, as an attorney who has consulted in many states across the country, I see more and more parents bravely coming forward in reliance on a belief that the courts will help protect them and their children. There are also more courts protecting children, sometimes turning cases around after a wrong decision. Even judges are acknowledging errors and missteps. Former judge DeAnn Salcido, in San Diego, admitted to inadequate judicial training in which she was taught not to trust women who make allegations of child abuse during custody litigation.

Change has come slowly. Many feel impaled by the courts. Those parents labeled uncooperative, unreasonable, too angry to settle, or too hostile to have joint custody have risked losing in efforts to protect their children. Since 70% of the protective parents risk losing not only custody, but also visitation and contact with their children, the "trip point" or threshold that changes the focus from child protection to parental rights has to be moved towards child protection (Saunders et al., 2011).

In spite of many frustrations and personal horror stories, the landscape across the country is changing. In 1980, when I began, there was no 911. Today, police respond to a 911 domestic violence call immediately and take security action between the parties in a manner that was impossible and unheard of 30 years ago. Domestic violence laws do protect many women and children.

We know what happened at Penn State, because one brave person came forward and the national media covered it. Without that one person, there would never have been others, and it turned into a landslide of informants with the confidence to come forward. As a nation, we trust the sources, partly because the victims have no ulterior motive, and it is a burden to come forward. In a microcosm, we know of the cover-ups, the social and cultural policies of ignoring and looking the other way rather than bringing it to the forefront. Penn Sate can be used as an analogy for other children in family courts, by showing that a trusted father figure can misuse his power to molest. The revered coach may symbolize the actual father who presents himself to any court in the US, the father who no one could imagine doing heinous acts to children.

What I learned as I began to synthesize this conversation with myself is that we must keep the issues of intimate violence and child abuse alive and in the public eye. As we keep talking about bias in the courts and the tragedies of tearing children from loving parents as a means of controlling supposedly uncooperative parents, we become part of the landslide of informants on a national scale.

With pressure, intimate violence training in public and private spheres will move forward ever more quickly. Courts and legislators will listen if a public outcry is consistent, since these issues affect everyone in their district.

This is not a woman's movement. It is a movement to ensure the safety and protection of children. There are icons in this movement, but every person, doing their part by doing a proper court evaluation, is educating the court and the public about the schism between the law and its implementation. We have grown and we have changed. What is being done is working. I urge each of you to grow your community. In writing and speaking and confronting these issues, I restore my own faith in community and a system that must succeed for all of us, but especially our children.

References

DV LEAP (Domestic Violence Legal Empowerment and Appeals Project), www.dvleap.org/

Eileen King: Child Justice, Inc., www.child-justice.org

Garland Waller, garwal@bu.edu

Leadership Council on Child Abuse and Interpersonal Violence, http://www.leadershipcouncil.org/

Saunders et al., (2011). Child custody evaluators' beliefs about domestic abuse allegations: Their relationship to evaluator demographics, background, domestic violence knowledge and custody-visitation recommendations; Final rechnical report submitted to the National Institute of Justice, U.S. Department of Justice, October 31, 2011.

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.*

International Committee

Elizabeth Carll, PhD, Chair

The mission of the International Committee is to ensure 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. We also continue to actively recruit student members who will be participating in the committee activities, including conducting interviews with international trauma psychologists residing outside of the U.S.

Elizabeth Carll, PhD

Atle Dyregov, PhD

Konstanttinos Papazoglou

The interview below with internationally recognized trauma psychologist Atle Dyregrov, PhD, conducted by student member Konstantinos Papazoglou, reveals insights about responding to the 2011 Norway Attacks and providing trauma services and training throughout the world. This is the third interview of international trauma psychologists conducted by committee students this past year.

To encourage participation of international students at the APA convention, the Division approved an award consisting of complimentary convention registration and a $300 student stipend to support travel. A free one-year membership in Division 56 is also included. The committee is currently determining the recipient of the award from among graduate student applicants from developing countries who submitted a poster or will be participating in a session at the 2013 convention in Hawaii. The committee will be recommending an increase in the amount of the travel award for the 2014 convention.

The committee organized a symposium for the 2013 convention, "International Perspectives on Intervention and Recovery Following Violence and Disaster," with participants Elizabeth Carll, Chair, United Nations NGO Committee on Mental Health; Vincent Sezibera, National University of Rwanda; Atle Dyregrov, Center for Crisis Psychology, Norway; and John Thoburn, Seattle Pacific University. Check convention brochure for date and time.

The committee continues to collect information on international trauma psychology programs both within the U.S. and globally. If you are aware of such programs, which are university based or established as ongoing institutes, please send information to Dr. Elizabeth Carll, Chair, Division 56 International Committee, at ecarll@optonline.net .

Interview With Atle Dyregrov, PhD
by Konstantinos Papazoglou, MA

Atle Dyregrov, PhD, is a clinical psychologist and Director of the Center for Crisis Psychology in Bergen, Norway, which he co-founded in 1988. He is the author of numerous books and research articles published in scholarly journals. His research and clinical focus include child trauma and loss, natural disasters, and survivors of torture and war. He collaborates with other trauma experts and presents and teaches his work and experience to numerous trauma scholars around the world.

Dr. Dyregrov encourages the transfer of knowledge from clinical practice to research work and vice versa. He states that such skill transfer is necessary to serve the public in large emergencies. Here researchers and practitioners can use a public health approach to reach out and help many trauma survivors on a community or a group level. In this way, greater numbers of trauma survivors can be reached than may occur in one-to-one therapeutic encounters.

Trauma psychologists need to employ evidence-based along with practice-based interventions in their work with trauma survivors, taking into consideration that research outcomes often need therapists' experience in order to become a tool of support for trauma survivors, according to Dr. Dyregrov. As an example, he referred to natural and manmade disasters, stating that experience from previous disasters enriches our clinical knowledge in helping survivors. On the other hand, Dr. Dyregrov

noted that therapeutic experience needs to be supported by research evidence.

Dr. Dyregrov mentioned that people in Norway—and Scandinavia in general—need more information about the role of crisis teams and the way the role of these teams is differentiated from that of a social support network. In Norway, more women than men are referred for psychological help after a trauma exposure because more women than men tend to ask for psychological help. However, young men seek out psychological help more often than older males. When asked about the impact of the July 22, 2011 mass killings in Oslo and Utoya Island on the way the public views trauma, Dr. Dyregrov highlighted that the public is overstimulated with the impact of trauma since the mass killing. He pointed out that after the incident, people had the opportunity to improve their knowledge in terms of loss and trauma because they were interested in keeping themselves aware of such issues. However, over time those who are not directly affected by the July 22, 2011 mass killing attacks downplay or underestimate the impact of these incidents.

In terms of the role of the group or the community in the healing process of trauma experience, Dr. Dyregrov said that the group is very important because "survivors support each other, identify common issues they may share, and spend time together improving the cohesiveness of the group." For instance, after the July 22, 2011 attack, survivors and intimate others of survivors, such as family members and friends, expressed that they wanted to meet others with similar experiences. As a result of their participation in a group, they were able to share common issues they experienced and learn from each other.

The role of leaders is very crucial in building cohesiveness and group support. Dr. Dyregrov contended that community leaders such as mayors, school principals, religious leaders, and others can play an important role in helping the local community members process trauma, share their experiences, and identify commonalities of these experiences. Also, mental health professionals need to provide training, support, and information to the community leaders.

When asked to identify the most significant challenges for trauma psychology researchers and clinicians, Dr. Dyregrov contended that more people around the globe—professionals and survivors—need to have access to trauma-related resources and services. For instance, psychologists in a remote area of Bangladesh may benefit from the availability of trauma-related resources such as scientific literature and contact with other trauma experts. Moreover, Dr. Dyregrov stated that current research primarily focuses on developing evidence-based interventions for longer-term therapy. However, he contended that researchers also need to prioritize the development of interventions that can be applied fairly shortly after the trauma exposure "from the very first moment and not only in the therapeutic context." These interventions are not traditional therapy, but guidance during a period that may determine future communication and cohesion in the family. Providing guidance to parents of traumatized children and teaching children recovery techniques have an important role.

In addition to these challenges, Dr. Dyregrov discussed the significant role of culture in helping trauma survivors. He stated that it is always important to respect the culture, but the culture is not always right and we must combine it with knowledge when we develop culturally relevant interventions. Different cultures are also "growing closer" in modern society, and this allows for many things to share and common values. Dr. Dyregrov highlighted that the interchange of knowledge among trauma scholars from different geographical areas is very important and said that he often applies knowledge that comes from trauma experts in the U.S.

Konstantinos Papazoglou *received his master's degree from New York University and is a PhD candidate in Psychology focusing on applied clinical research at the University of Toronto. He was also a police captain at the police academy in Athens, Greece. He has published in peer-reviewed journals and received research grants and awards. He is a student member of the International Committee of the Trauma Psychology Division of APA.*

Seeking APA Members With Expertise in Latino LGBT Youth

Heartland Alliance International (HAI) is working with the federal Office of Refugee Resettlement to train staff in programs throughout the United States to identify and better respond to the needs of undocumented immigrant LGBT youth who have been transferred from the custody of the Department of Homeland Security to the Department of Health and Human Services. This year, approximately 14,000 minors were detained by Customs and Border Patrol. The majority are from Central America, and most will be released to relatives or placed in foster care here in the United States. Some LGBT minors fled abuse and neglect at home, and may have experienced sexual abuse or violence during the migration process. This population has unique clinical, legal, and social service needs. Heartland Alliance International is seeking to contract psychologists with expertise in sexual orientation and gender identity among Latino youth to assist in developing a trauma-informed curriculum for mental health providers, and to provide a series of training sessions. Please contact Scott Portman at sportman@heartlandalliance.org or Daniel Weyl at dweyl@heartlandalliance.org.

Dual Roles and Forensic Psychology: A Trauma Informed Perspective

Tyson D. Bailey, PsyD

Forensic psychology is a unique specialty in our field, which involves the blending of psychological knowledge and the legal system. While many Early Career Psychologists (ECPs) do not set out to work in a forensic setting, anyone who sees clients carries some risk of being involved in the court system during his or her career. This may be particularly true for professionals who work with trauma survivors, as this population can be vulnerable to further victimization, especially those who have a history of repeated abuse in their childhood (Briere & Jordan, 2009; Herman, 1992). In addition, some survivors of traumatic events may decide to engage legal services as part of their healing process. The author's experience has shown that court proceedings can become a third party in the room that can disrupt the alliance, which is a cornerstone of effective trauma treatment (Herman, 1992). In addition, the work often shifts in focus to a more psychoeducational stance to ensure the client understands how his or her notes will be used and how the therapist's behavior will be different in the courtroom. Although this transformation can ultimately assist the client in maintaining a grounded perspective in a chaotic environment, it may also represent a breach in trust for individuals who already struggle with maintaining a sense of stability and safety in the world. Focusing on a caring, compassionate, and psychoeducational stance can have a significant positive impact on the client's overall mental health and experience of the process; however, it can also put the clinician in a precarious position if he or she is not aware of the distinction drawn between a forensic expert and a treating therapist.

Tyson D. Baily, PsyD

Although there are people in the field who specialize in forensic practice, all clinicians should have an awareness of how their notes, testimony, and clinical expertise can facilitate or hinder the therapeutic relationship and the court proceedings. For example, a client could use worsening mental health as part of a sexual harassment lawsuit against an employer, or a parent's mental health status may be raised during the course of a contentious divorce. Greenberg and Shuman (1997, 2007) indicate that it is important for clinicians to understand and be able to discuss the distinction between a treating therapist and an expert witness with their client and his or her attorney. The primary reason for this role differentiation is based on the information the individual is able to provide in court. A treating therapist has one source of data—the client. He or she is considered a fact witness; it is not his or her job to opine, establish causation, or determine truth (American Psychological Association [APA], 2011; Strasberger et al., 1997). Instead, therapists are generally relegated to testifying as to observed behavior and reports the client has made about his or her subjective experience while in therapy sessions. On the other hand, an expert witness utilizes multiple data sources, including psychological tests, depositions, and extensive records. Therefore, he or she may offer opinion-based testimony and infer conclusive statements from the work of others (APA, 2011; Strasberger et al., 1997). The expert is expected to remain neutral and base his or her conclusions on the patterns found in the data in conjunction with the most up-to-date research. This distinction should not be minimized, as it can have a profound effect on the therapeutic relationship, the client's well-being, and the outcome of the trial.

Though there are strict guidelines against entering into a dual relationship with clients (APA, 2010), therapists who work with individuals in the litigation process are often asked to step into one of the grey areas described in the ethics code (Greenberg & Shuman, 1997, 2007; Strasburger et al., 1997). While this blurring of roles can be difficult for most clients, it can be especially problematic for those who have experienced traumatic boundary violations. Due to the potential harm to the client and the therapeutic relationship, clinicians are generally discouraged from concurrently being the treating therapist and the expert witness (APA, 2010, 2011). There are several instances when this rule may be waived, such as when there are no other options because of the size of the community, a particular institution requires it, or the law specifically mandates the blending of the two roles (APA, 2010). Asking a therapist to cross over to the expert role, except in circumstances where it is not possible to hire someone else (i.e., in a remote rural community), represents a dual role and has the potential for significant consequences to the client and the therapeutic relationship (Greenberg & Shuman, 2007).

Strasburger et al. (1997) state that many attorneys believe the treating therapist can and should serve in both roles because they are better acquainted with the client, and often less expensive than a forensic expert. Although some attorneys are amenable to being educated about the problematic ethical conundrum this imposes, not all will take kindly to the therapist maintaining firm boundaries around this issue. Perhaps the most important way to combat this issue is having transparent discussions with clients about how a treating therapist can be helpful, which is consistent with maintaining safety and stabilization in treatment (Herman, 1992). Drawing a distinction between the two roles can also be helpful for clients, so they have a better understanding of why it is important for the therapeutic relationship and the integrity of their case to have the clinician maintain his or her boundaries. Regardless of the preparation, this can be a difficult stance to maintain when the attorney is applying pressure to both the clinician and the client. However, we are ethically bound to uphold those behaviors that prevent harm to our clients, making this decision non-negotiable. ECPs are particularly vulnerable to the seductive lures offered by attorneys in these instances, particularly when cash flow is unstable and the attorney implies that unwillingness to cooperate with the attorney's agenda may lead to the alienation of a potential referral resource.

The intersection of psychological practice and the law can be difficult to navigate, especially if a client has a history of trauma, making it crucial to seek supervision or consultation if one is not familiar with how court cases can affect the therapeutic relationship. Although dual roles are an ethical concern with every client, trauma survivors may be particularly vulnerable to experiencing negative effects when a clinician enters a gray area without fully informing the client. Clinicians may become as distressed as the client if they become part of the litigation process because of the inherently non-therapeutic nature of the legal system; however, the benefits that therapy can provide for individuals going through a lawsuit cannot be understated. Given that any client could potentially submit his or her mental health records as part of a legal case, it is crucial that all therapists become aware of how to remain well-boundaried with both their client and any representatives of the court. Therapists should also keep all records as if they might become part of future court proceedings. Maintaining this stance of clarity regarding the boundaries of therapy while remaining aware of a current or potential forensic context can increase the likelihood of the client remains connected with the therapist through the inevitable ruptures of being involved in the legal process, so that therapy can resume once the invisible third party is no longer present.

References

American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct:* Retrieved January 2, 2013, from http://www.apa.org/ethics/code/index.aspx

American Psychological Association. (2011). *Specialty guidelines for forensic psychology:* Retrieved January 2, 2013 from http://www.apa.org/practice/guidelines/forensic-psychology.aspx

Briere, J. & Jordan, C.E. (2009). Childhood maltreatment, intervening variables, and adult psychological difficulties in women: An overview. *Trauma, Violence, & Abuse, 10,* 375-388.

Greenberg, S. A., & Shuman, D. W. (1997). Irreconcilable conflict between therapeutic and forensic roles. *Professional Psychology: Research and Practice, 28,* 50-57.

Greenberg, S. A., & Shuman, D. W. (2007). When worlds collide: Therapeutic and forensic roles. *Professional Psychology: Research and Practice, 38,* 129-132.

Herman, J. L. (1992). *Trauma and recovery: The aftermath of violence—From domestic abuse to political terror.* New York: Basic Books.

Strasburger, L. H., Gutheil, T. G., & Brodsky, A. (1997). On wearing two hats: Role conflict in serving as both a psychotherapist and forensic expert. *The American Journal of Psychiatry, 154,* 448-456.

Tyson Bailey *completed his doctorate in clinical psychology at Argosy University, Seattle in 2011. He is a licensed clinical psychologist in Washington State who maintains a private practice that focuses on both assessment and treatment of posttraumatic distress. He completed two years of graduate training and is currently a postdoctoral fellow at the Fremont Community Therapy Project. His dissertation research was on interpersonal trauma survivors in the martial arts, and he is currently a research assistant for the Trauma Institute with Dr. Ricky Greenwald. He is an author on several pending publications, including the Division 56 Guidelines for Psychologists Regarding the Assessment of Trauma in Adults. He has also been involved in the martial arts as a student and teacher for 15 years.*■

Attention Early Career Psychologists!

The APA would love to stay in touch with Early Career Psychologists and Early Career Psychologist leaders in our division! Please consider joining the Early Career Psychologist Listserv and/or the ECP Leadership Network. There are some very good initiatives underway such as ECP Virtual Happy Hours and Leadership Institutes that train ECPs for increasing involvement in the Divisions and the organization overall. For more information, please see www.apa.org/careers/early-career/get-connected/index.aspx

Trauma Education: One Student's Learning Curve

Zachary D. Bloom, MA

At my clinical site, a non-profit agency in central Florida, interns and therapists are responsible for building their caseloads by combing through several logs of phone screening forms and then contacting potential clients. After completing the documentation and policy trainings mandated by my site, I found myself looking for my first client by staring at an endless list of names with an assortment of presenting problems. I chose a client experiencing symptoms of anxiety and depression, and I was excited to make my first phone call. After years of academic reading, classroom role-plays, and some limited experience working with clients in practicum, I was confident in my ability to handle anything. By the time my first client came in for her intake interview, I had already built a potential treatment plan in my mind that involved identifying coping strategies, practicing relaxation techniques, and creating a genogram. My first session with a real client was going to end with the hearty cheers and applause of every therapist in the building; I was sure of it.

Zachary D. Bloom, MA

In reality, my first session ended with a firm handshake and the foundation of a therapeutic framework just like my counseling program trained me to do. Over time, my caseload increased in size, and I gained experience in treating clientele with a variety of presenting symptoms. However, I became aware that I was cherry picking clients whose presenting concerns did not involve trauma. I came to realize that I was doing this because I only felt confident in my ability to be a successful counselor when working with clients who had presenting issues I was familiar with from my academic training, such as anxiety and depression. Indeed, where most counseling programs drop the ball in meeting the needs of future counselors is training practicum students and graduate interns to assess for and treat trauma (Black, 2008), and my program was no exception. Moreover, because of my lack of knowledge on the subject and my personal reactivity to hearing emotional and painful experiences, I found myself feeling incompetent when presented with these cases.

Regardless, I gradually came to understand that I was cheating myself out of the opportunity to grow as a counselor when avoiding clients with presenting issues that intimidated me. Besides, my attempts to avoid trauma were not entirely successful as many of my clients reported traumatic experiences even if that was not their presenting problem. I came to learn that trauma does not present itself in the neatly packaged ways I expected such as veteran war stories, sexual abuse, and violence. Rather, my clients' trauma came under the guise of car accidents, watching loved ones die, and other frightening experiences. In retrospect, it should not come as a surprise that I found trauma in my caseload of clients. Trauma is widespread throughout the United States and is experienced by 75% of the general population (Mills et al., 2011).

The first client to disclose her trauma to me was a woman who reported she was a survivor of sexual assault. As she told her story, my heart sank into my stomach as I empathized with her pain and imagined the horror she had experienced. Slowly, terror crept into my throat as I wondered how to respond to her. My eyes moved to hers to see what kind of emotional weight those words carried for her, and I was awestruck to find none. It was blatantly apparent that my client was entirely disconnected from her feelings. As much as I wanted help her, I did not know what she needed from me. Even if I had known, I was too busy having my own reaction to her story, sitting with the weight of it in my stomach. The conversation moved on without addressing her trauma further, and I was relieved. Leaving the counseling session some time later, the sickness I felt turned to frustration and disappointment with myself for my inability to be an effective counselor in that moment. Several sessions later, I discharged my client, who reported that counseling helped her and she was no longer in need of services. However, I was left wondering if I could have helped her more if I had known how to work with her trauma.

After that final session, I spoke with my internship supervisor about my feelings of inadequacy when working with trauma survivors. Through many sessions of individual supervision, I came to see that I was burdening myself with a sense of responsibility to "fix" my clients. It was an impossible task and was getting in the way of what I could offer my clients: support, coping strategies, validation, and an opportunity to gain awareness and insight into the lasting effects of trauma. Through supervision, I learned that not all trauma needs to be addressed. I also came to appreciate that as graduate interns, it is important for us to remember that we are still students learning the craft. As such, we are doing ourselves a

disservice if we limit our clinical experiences for fear of our lack of clinical competency. For that reason, it is of utmost importance that we take on clients that appear challenging so long as we seek supervision and consultation. It is the only way we will gain the experience necessary to become competent to counsel diverse populations. In the meantime, students can take comfort in knowing that recent research shows that psychology interns can be as effective as experienced counselors in creating successful client outcomes (Nyman, Nafziger, & Smith, 2010).

Upon graduation and eventual licensure, I envision myself continuing my education in order to have a future career in counselor education and supervision. Additionally, I would like to specialize in working primarily with families and couples. While trauma work specifically is not my area of focus, I feel that I will need to receive specialized training in order to benefit future clients as I have seen how many people suffer from trauma. Therefore, with the guidance of my clinical supervisor, I have decided to enroll in a 30-hour training and certification for Eye Movement Desensitization and Reprocessing Therapy (EMDR), which has been proven to be as effective as CBT in the treatment of trauma (Seidler & Wagner, 2006).

While training and certification in EMDR will give me a greater understanding of trauma and greater confidence in working with clients who have survived trauma, it is not the sole solution to treating trauma. There are many different strategies for working with trauma, and with my growing experience as a counselor, I have developed some strategies that work well for me:

First, establish strong rapport with clients and ensure that they feel safe and comfortable within the therapeutic framework of our sessions. I do this by respecting my clients' boundaries and not pushing them to discuss their trauma when it is inappropriate in the session or when my clients' feelings become too intense.

Second, do not ignore clients' trauma. Often, discussing the trauma is a great bridge to teaching them a variety of relaxation and grounding techniques to help them stay present and calm in the face of overwhelming feelings.

Third, seek supervision and consultation at every available opportunity to process one's own reactions to hearing clients' trauma histories. Supervision and consultation are also perfect times to address any concerns about clients with trauma symptoms that may be too severe for the present level of care. For clients who meet the criteria of Posttraumatic Stress Disorder or who otherwise need a specialist, it is essential to refer them to a clinician who specializes in trauma and can use evidenced-based treatment.

Finally, when working with clients with a history of trauma, I follow another rule for myself: self-care. Whether by the name of "burnout" or "vicarious trauma," it is a well-known phenomenon that counselors can develop secondary reactions to clients' trauma (Trippany, White Kress, & Wilcoxon, 2004). Therefore, I make sure that I end every day by doing something for myself. In a profession where we work hard without always seeing the immediate benefits to our work, we have to trust the process of counseling, remember that we are doing good work even if we are not yet experts in our field, and take the time to take care of ourselves.

References

Black, T. G. (2008). Teaching trauma without traumatizing: A pilot study of a graduate counseling psychology cohort. *Traumatology*, *14*(3), 40-50. doi: 10.1177/1534765608320337

Mills, K. L., McFarlane, A. C., Slade, T., Creamer, M., Silove, D., Teesson, M., & Bryant, R. (2011). Assessing the prevalence of trauma exposure in epidemiological surveys. *Australian and New Zealand Journal of Psychiatry*, *45*, 407-415.

Nyman, S. J., Nafziger, M. A., & Smith, T. B. (2010). Client outcomes across counselor training level within a multitiered supervision model. *Journal of Counseling and Development*, *88*(2), 204-209.

Seidler, G. H., & Wagner, F. E. (2006). Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: A meta-analytic study. *Psychological Medicine*, *36*(11), 1515-22. doi: 10.1017/S0033291706007963

Trippany, R. L., White Kress, V. E., & Wilcoxon, S.A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling and Development*, *82*(1), 31-37.

Zachary D. Bloom *is in his final semester at Rollins College in central Florida where he will graduate this May with a Master's Degree in Mental Health Counseling and a certificate in Marriage and Family Therapy. He hopes to enjoy a long summer traveling and visiting with friends and family back home in the suburbs of Chicago before entering the University of Central Florida's Doctoral Program in Counselor Education and Supervision this fall.*■

Social Media News

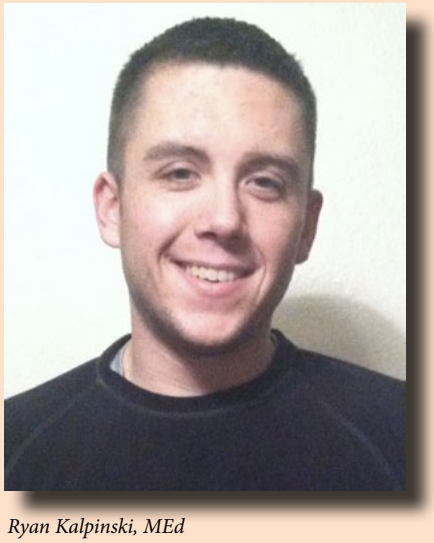
Division 56 is now on social media! Please join us to get the latest announcements, Division 56 news and events, and related trauma psychology news.

Facebook:
https://www.facebook.com/apadivision56
Twitter:
https://twitter.com/APADiv56
LinkedIn:
go to http://www.linkedin.com and search in groups for Division 56

Veterans Self-Medicating for PTSD: An Unfortunate Mixture

Ryan Kalpinski, MEd
Texas A&M University

Substance abuse is a significant problem for many veterans and service members across our nation, with potentially devastating personal and societal consequences if left untreated. The unfortunate reality for many who struggle with substance abuse is that they have experienced one or more traumatic events during their lives. Although people often experience some distress after a traumatic event, serious concerns arise when individuals display symptoms significant enough to meet criteria for both Post-Traumatic Stress Disorder (PTSD) and Substance Use Disorders (SUD). With the increase in traumatic experiences reported as a result of the Iraq and Afghanistan conflicts, there is a corresponding increase in substance abuse among service members and veterans (Milliken, Auchterlonie, & Hoge, 2007; Jacobson et al., 2008). To address SUD and PTSD as a public health issue, we must look at prevalence, potential causes for such high co-morbidity rates, possible solutions, directions in the field, and potential opportunities for professionals wanting to assist in this process.



Ryan Kalpinski, MEd

The high co-occurrence of SUD and PTSD among veterans has become a nationwide concern. A recent systematic review of the literature found prevalence estimates of PTSD among SUD samples of both civilian and military populations to be anywhere from 11% to 41% (van Dam, Vedel, Ehring, & Emmelkamp, 2012). In a national Vietnam veteran readjustment study by Kulka and colleagues (1990), the authors estimated that 75% of Vietnam veterans with lifetime PTSD had co-occurring SUD. Research also found that veterans with PTSD experience more serious legal problems, have higher long-term use of alcohol and other substances, and more health problems throughout their lives (Pandiani, Rosenheck, & Banks, 2003). Such staggering estimates require careful consideration by mental healthcare practitioners and policy makers to lessen the impact for our nation's heroes.

To address potential causation, there are three main hypotheses that attempt to explain the link between PTSD and SUD (van Dam et al., 2012). First, the *Self-Medication* hypothesis proposes that veterans who frequently use substances after experiencing symptoms of PTSD will associate onset of traumatic symptoms with a need for substances for relief. This hypothesis also suggests that physical effects of substance withdrawals such as rapid heart rate, shaking, sweating, and nervousness, are similar to the fear response experienced in life-threatening situations and may subsequently trigger traumatic responses. Secondly, the *High Risk* hypothesis indicates that individuals who use or abuse substances are more susceptible to dangerous activities, and are therefore more likely to encounter traumatic experiences. Lastly, the *Diathesis-Stress Model* focuses on a biological predisposition or an inability to cope well with stress that affects how intensely we experience the effects of a traumatic stressor. Although results are inconclusive, ongoing research supports the idea that the three main causal pathways are ecological, residual stress, and biological in nature (McKeever & Huff, 2003).

Regardless of the potential reasons veterans choose to abuse substances, it often begins as a welcome relief from the emotional pain that they experience on a daily basis. Unfortunately, substance use does produce a perceived and temporary relief from emotional or psychological discomfort related to traumatic experiences; however, there are often significant long-term consequences. Due to the availability and fast-acting nature with which substances effectively medicate trauma-related distress states, substance use can easily become the method of choice. In addition, there remains a significant amount of stigma associated with seeking mental health services upon returning from war. Alcohol, however, is one of the most readily available substances on the market. Furthermore, it is culturally normative for young adult males (ages 18-35), who make up the majority of our military and new veteran populations, to drink heavily in social situations (Bernhardt, 2009). The combination of emotional, cognitive, and physical effects associated with co-occurring PTSD and SUD can lead to difficulty maintaining functional capacities and decrease compliance with treatment. Additionally, the fact that drinking is an accepted form of dealing with emotional distress in our society can influence the lack of adherence to abstinence-based treatment programs, and may indicate a need to develop more harm reduction programs for veteran populations. Therefore, researchers

and practitioners must continue developing and refining effective treatments to address the issue of reduction in incidence rates.

Providing efficient and high-quality services can be difficult, as program type and availability vary greatly among states and is ever changing based on availability of specialized personnel and funding. When investigating medical service utilization among veterans with PTSD, findings suggest that they are more likely to receive services from non-mental health clinics (Calhoun, Bosworth, Grambow, Dudley, & Beckham, 2002). The authors also suggested that screening veterans for PTSD in primary care settings may be helpful, but recognized a lack of evidence for potential benefits of PTSD screenings in primary care. Screening veterans will take added training and effort from primary care physicians, but may assist in the critical early detection of and treatment for PTSD and SUD. Among veterans, early detection and proper treatment of co-occurring SUD and PTSD could reduce the chance for repeated relapses and low treatment adherence, which could also decrease the length of waitlists for treatment programs. In general, psychotherapy was found to reduce medical costs, adding to the benefits of integrating psychological components to primary care (Gabbard, Lazar, Hornberger, & Spiegel, 1997). In an effort to address this issue, there has been a push to increase primary healthcare support in active duty military settings. For example, the Behavioral Health Optimization Program (BHOP) places psychologists in a primary care setting to provide immediate care to patients visiting their doctor who exhibit psychological symptoms. This process may reduce chances for false-negative screening results, reduce stigma for seeking mental healthcare, allow for brief interventions, and potentially increase treatment adherence.

Treatment for co-occurring SUD and PTSD is a complex process with many setbacks possible, especially when the person has experienced numerous traumatic events during his or her life. For example, men seeking treatment for substance abuse who also experienced childhood sexual abuse were found to have substantially more relapses than their non-traumatized counterparts (Como-Kepler, 1998). After sobriety is achieved, underlying issues that led to substance abuse can be overwhelmingly vivid and distressing. In addition, when people suffering from PTSD reach sobriety for extended periods without receiving help to process their emotional experiences, it is less likely they will remain abstinent. Given helpful tools to cope with emotional and psychological discomfort, affected individuals can often sustain their improvement from SUD for longer periods of time.

Widely accepted models of recovery from SUD and PTSD initially focus on safety for individuals to become healthy and free from substance use before beginning an intense focus on traumatic experiences. Judith Herman (1992) defined the three fundamental stages of trauma recovery as establishing safety, reconstructing the traumatic story, and restoring the connection between the survivor and his/her community. *Seeking Safety*, a treatment manual written by Lisa Najavits (2002), is a widely accepted manualized treatment specifically formulated for co-occurring SUD and PTSD. Assisted Recovery from Trauma and Substances is a treatment program that focuses first on treating addiction with Cognitive Behavioral Therapy (CBT) and then utilizes stress inoculation training for PTSD. Other treatments regularly implemented to treat dual-diagnosis patients are Relapse Prevention, Transcend, CBT, Motivational Interviewing (MI), Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR). Ideally, a dual-diagnosis treatment program would utilize several of the above approaches to reach the individual needs and learning styles of various patients seeking treatment.

For those veterans dealing with substance-related legal repercussions, early recommendations for treatment could help reduce costs and help them decrease the likelihood of becoming a repeat offender. Moreover, individuals given the option of treatment versus incarceration, have a chance to avoid an environment that can worsen symptoms of PTSD. Exacerbation of posttraumatic symptoms including hypervigilance, sleep problems, and re-experiencing can occur when constantly surrounded by strangers in a chaotic and stressful environment. Finally, from a public health perspective, substance abuse treatment programs are already recommended by the CDC and have the potential to save the general public from unnecessary danger. The benefits increase as treatment becomes more effective with the added detection and treatment of PTSD when appropriate.

New practitioners considering work with military or veteran populations have a unique opportunity to help in the effort to reduce the burden of trauma for those who serve this country. Luckily for Early Career Psychologists (ECPs), military branches and the VA are cognizant of the increased need for new practitioners to focus on the treatment of PTSD as well as SUD. In a memorandum from the Secretary of Veterans Affairs on June 11, 2012, it was announced that 1,600 mental health clinicians and 300 support staff would be added to meet increased demands for mental health services. The memorandum also mentioned, in an effort to quickly and efficiently begin the hiring process, the development of an "aggressive national recruitment program."

On the active-duty side, the United States Air Force, Army, and Navy all offer a Health Professions Scholarship Program. Doctoral Level Counseling and Clinical Psychology students enrolled in APA-accredited training programs are encouraged to apply for 1-to-3-

year scholarships that cover tuition and fees as well as a monthly stipend during graduate training. Upon graduation, recipients will serve as full psychologists on active duty. Scholarship recipients often fill leadership roles in the military, which provides an opportunity to help reduce the impact of psychological trauma on those who serve in active duty capacities. Each branch offers extensive training in some of the most supported evidence based practices and quickly advances ECPs in the field.

Posttraumatic symptoms, including substance use and abuse, continue to be a significant problem for returning veterans. There is currently a high demand for qualified individuals to assist in their treatment. Many recommendations were made in the present article in hopes that new research and education may lead to greater awareness of, and treatment for, people affected by SUD and PTSD nationwide. The likelihood of successfully treating people for SUD and PTSD greatly increases with patients' ability to remain sober and focus on treatment to correct their emotional experiences (Ouimette, Moos, & Finney, 2003). With the demand growing on a daily basis for professionals competent in treating co-occurring disorders in veterans, it is critical that training programs inform their students about the options available to serve this population, and for ECPs to consider pursuing a research or clinical career focused on decreasing substance abuse and the lingering effects of trauma.

References

Bernhardt, A. (2009). Rising to the challenge of treating OEF/OIF veterans with co-occurring PTSD and substance abuse. *Smith College Studies In Social Work, 79*(3-4), 344-367.

Calhoun, P. S., Bosworth, H. B., Grambow, S. C., Dudley, T. K., & Beckham, J. C. (2002). Medical service utilization by veterans seeking help from posttraumatic stress disorder. *American Journal of Psychiatry, 159*(12), 2081-2086.

Centers for Disease Control and Prevention. (2009). Impaired driving. Retrieved April 2, 2012, from http://www.cdc.gov/MotorVehicleSafety/Impaired_ Driving/impaired-drv_factsheet.html

Como-Kepler, D. *Childhood sexual trauma in men and subsequent substance abuse. Dissertation Abstracts International: Section B: The Sciences and Engineering,* 6230. Retrieved from http://lib-ezproxy.tamu.edu:2048/login?url=http://search.proquest.com/docview/619380155?accountid=7082.

Gabbard, G. O., Lazar, S. G., Hornberger, J., & Spiegel, D. (1997). The economic impact of psychotherapy: A review. *American Journal of Psychiatry*, *154*(2),147-155.

Herman, J. L. (1997). *Trauma and recovery: The aftermath of violence from domestic abuse to political terror* ([Previous ed.: 1992] ed.). Basic Books. ISBN 0-465-08730-2.

Jacobson, I. G., Ryan, M. A. K., Hooper, T. I., Smith, T. C., Amoroso, P. J., Goyoko, E. J., … Bell, N. S. (2008). Alcohol use and alcohol-related problems before and after military combat deployment. *Journal of the American Medical Association, 300*(6), 663-675.

Kulka, R. A., Schlenger, W. E., Fairbank, J. A., Hough, R. L., Jordan, K. B., Marmar, C. R., & Weiss, D. S. (1990). *Trauma and the Vietnam war generation: Report of findings from the National Vietnam Veterans Readjustment Study.* Philadelphia, PA: Brunner/Mazel.

McKeever, V. M., Huff, M. E. (2003). A diathesis-stress model of posttraumatic stress disorder: Ecological, biological, and residual stress pathways. *Review of General Psychology*, *7*(3), 237-250.

Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *Journal of the American Medical Association, 298*(18), 2141-2148.

Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse.* New York: Guilford Press.

Office of Public and Intergovernmental Affairs. (2012, June 11). *Memorandum: VA announces aggressive national recruitment effort to hire mental health professionals.* Washington, DC: Department of Veterans Affairs.

Ouimette, P. C., Moos, R. H., & Finney, J. W. (2003). PTSD treatment and 5-year remission among patients with substance use and post traumatic stress disorders. *Journal of Consulting and Clinical Psychology, 71*(2), 410-414.

Pandiani, J. A., Rosenheck, R., & Banks, S. M. (2003). Elevated risk of arrest for Veteran's Administration behavioral health service recipients in four Florida counties. *Law & Human Behavior*, *27*(3), 289-298.

van Dam, D., Vedel, E., Ehring, T., & Emmelkamp, P. M. G. (2012). Psychological treatments for concurrent posttraumatic stress disorder and substance use disorder: A systematic review. *Clinical Psychology Review, 32*(3), 202-214.

Ryan Kalpinski *is a doctoral candidate at Texas A&M University in counseling psychology. He is the recipient of a Health Professions Scholarship from the United States Air Force. When possible, Ryan enjoys being outside camping, hiking, fishing, and hunting. His clinical experiences include community mental health clinics, correctional facilities, Veterans Administration Medical Center (Trauma Recovery Program), and a VA Substance Abuse Treatment Program. Ryan's dissertation is an investigation of therapeutic outcomes in a federally qualified healthcare center counseling and assessment clinic. When Ryan begins his tour of service as a Clinical Psychologist and Captain in the USAF, he will work as a generalist practitioner but hopes to continue expanding his knowledge of trauma in an active-duty setting.*■

Division 56 Listservs

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

- div56@lists.apa.org—discussion among members
- div56childtrauma@lists.apa.org—child trauma topics
- div56dissociatiion@lists.apa.org—post-traumatic dissociative mechanisms development
- div56ecpn@lists.apa.org—early career psychologists networking
- div56stu@lists.apa.org—student form

Trauma and Social Justice Task Force: Highlight on Infant Mental Health

Charlotte Savage, PsyD

This month, a special report from the Division 56 Social Justice Task Force on the recent ZERO TO THREE National Training Institute on early intervention, an important example of inventive work that transverses social justice and trauma psychology.

ZERO TO THREE is a non-profit national organization dedicated to improving the health and welfare of infants, toddlers, and their families through providing information, training, and support. This past winter in Los Angeles, ZERO to THREE held its 27th training conference to present the latest in early childhood science, policy, and practice for clinicians. Conference attendees reported feeling inspired and encouraged being surrounded by like-minded others who understand the critical importance of early intervention as well as the challenging nature of this work. The conference presentations involved services at every level, ranging from prevention and advocacy, to intervention. Here are just some highlights to inspire, encourage, and inform our division members on the work being done with infants, toddlers, and their families.

Charlotte Savage, PsyD

Howard Stevenson, PhD, associate professor at the University of Pennsylvania and researcher for the National Center on Fathers and Families, presented an innovative program he developed with his colleagues Lorretta and John Jemmott called the Brother to Brother Barbershop Project. This program involves teaching African-American barbers counseling skills focused on violence and HIV/STD reduction strategies in order to provide help to 18-21-year-old African American males during their haircut appointments. This project is a National Institutes of Health-funded study that will last through 2014. Dr. Stevenson is also currently involved in work that emphasizes fatherhood and increasing positive father involvement in children's development as well as developing a program called "Can We Talk?," a school-based racial negotiation skills-building intervention for teachers and students to reduce negative stress reactions in student-teacher relationships. At the conference, Dr. Stevenson participated in reflective dialogue with other infant mental health specialists about the process of responding to challenging behavior and circumstances with wisdom.

Carmen Rosa Norona, MSEd; Maria St. John, PhD; and Kandace Thomas, MPP, presented the Diversity-Informed Tenets of Infant Mental Health. They developed 10 principles to help guide and empower individual practitioners, agencies, and systems of care to identify and address social justice issues. The Tenets are a vision of moving society and our field towards one where all infants and toddlers will be recognized, respected, and served regardless of racial and ethnic identity, ability, and family structure. They found that while there is universal recognition of the importance of protecting and promoting the well-being of infants and young children, there are problems implementing equitable practices. They attribute this to the cultural and institutional barriers that arise from inequities in race, class, and other areas in which we all live and work. The Tenets fall into three categories: stance towards children and families, practice and research principles, and broader advocacy. Their session involved a presentation of the Tenets, discussion of the struggles that arise in various spheres of practice, and development of strategies to use the Tenets to strive towards social justice in our practices.

Alicia Lieberman, PhD, Endowed Chair of Infant Mental Health at the University of California San Francisco, made several presentations demonstrating interventions that promote trauma and social justice at several levels, including at more individualized or micro levels as well as at more macro levels such as prevention and institutionally focused interventions. Dr. Lieberman is also the Director of the Child Trauma Research Project in San Francisco, a program that provides intervention to young children and their caregivers who have experienced domestic violence or other interpersonal trauma. Treatment lasts for one year and is comprised of joint child-parent psychotherapy aimed at improving the parent-child relationship, helping both parent and child better modulate their feelings, and helping the parent understand the child's experience so that the parent can become more effectively protective. Her current work focuses on intervening to prevent intergenerational transmission of trauma, treatment outcome research on effectiveness of child-trauma psychotherapy, and the impact of domestic violence and chronic traumatic stressors on early mental health and child development. In one breakout session, she presented with Chandra Ippen, Joy Osofsky, and

Patricia Van Horn on strategies to help clinicians and institutions integrate a focus on trauma through the use of Child-Parent Psychotherapy (CPP) in community mental health settings.

In another breakout session, Dr. Lieberman presented on trauma at a more micro level, addressing direct interventions in fear defenses in young children and their caregivers. She indicated that there are universal fears we all experience such as fear of loss (of caregiver, of love, of approval), fear of body damage, fear of "being bad," or fear of not living up to the expectations of those who love us. In early childhood, fear is a core organizer of experience and young children regularly process the somatic, cognitive, emotional, and interpersonal lessons arising from experiences of fear, safety and danger, approval and disapproval, the permitted and forbidden, and the other dualities that occur in life and relationships. In healthy families, caregivers are able to help the child work through these fears. While they may or may not resolve the issues fully, "healthy enough" families can help children tolerate these fears and understand they are still loved. However, in families with unresolved traumatic events, fears become reinforced instead of worked through. When children feel unprotected, they experience somatic and behavioral dsyregulations they find intolerable. In order to protect themselves, children develop behaviors that give them the illusion of mastery such as "controllingness" or aggression, avoidance, and withdrawal. She reviewed interventions that promote safety, self-regulation, attunement, and improving the parent-child relationships, as well as reducing fear and fear-defending behaviors.

As we all know, there are extensive parallel processes that can occur in trauma work and providers can experience vicarious traumatization while engaging in this work. Thobkile Mbanda; Anannakai Nalo, LCSW; and Jackie Schalit presented their work that reminded us of the importance of self-care and staff care when working in trauma-saturated communities. The presenters work in two cooperating agencies in the United States and in South Africa on programs for infants and young children in settings highly impacted by trauma. They noted that the impact of high trauma communities may lead to toxic stress in the child development setting itself. In their agencies, the presenters both noticed issues of secondary traumatization, burnout, countertransference issues, and compassion fatigue. They utilized trauma theory and reflective practices in their work to combat toxic stress. Reflective practice tools utilized in their agencies include breathe exercises, highlighting the positive, providing time for staff to reflect together in support, the importance of being held in someone's mind, and slowing down the experience. They demonstrated the use of reflective processing in debriefing and coping with two difficult case studies. They reiterated the importance of getting support, building in processes to protect ourselves and our clients, and remembering that being with one another through something difficult or the recounting of something difficult is a powerful intervention.

There was repeated emphasis throughout the conference on the importance of advocacy. In fact, this year, ZERO TO THREE established the Reiner Award for Advocacy on Behalf of Young Children to honor the extraordinary leadership of Rob and Michele Reiner on behalf of toddlers and babies. The Reiners presented the first award at the conference to Robert Duggar, PhD, co-founder of ReadyNation, a group dedicated to helping engage and inspire champions for babies and to increasing advocacy for young children at the local, state, and national levels. His work "has engaged and inspired a multitude of uncommon champions for babies and broadened the scope and possibility for positive action on behalf of young children" (Zero to Three, 2012).

Dr. Duggar's message at the conference emphasized the importance of the family in helping children develop healthily in the emotional and social arenas, indicating this is critical to the U.S. fiscal success. He stated that the United States has historically led the world in producing fully competent workers, but this, however, is no longer the case. The United States used to develop adults who were strong not only in academic skills, but also in soft skills such as motivation, self-regulation, timeliness, and self-esteem. These skills led to a strong workforce and fiscal success in the marketplace. The country is now falling behind other nations. Dr. Duggar emphasized that the work of early childhood is developing soft skills as well as building the foundation for later academic skills, and reiterated that it is vital that we invest in early childhood and families to ultimately help the financial success of our nation. The mission of his organization, ReadyNation, is "to help state and business and philanthropic leaders build strong coalitions to support smart early childhood spending—spending that strengthens families and future workforce competiveness," (ReadyNation, 2012). He has developed social impact finance programs for coalitions to increase funding and demonstrate the economic power of quality early childhood investments. Finally, Dr. Duggar emphasized the need for us to advocate and be able to speak financially in gaining funding for early childhood and family work. (For more information visit http://www.readynation.org/SIB/). We hope you found it inspiring and encouraging to hear some of the work that is being done in this important area of early childhood and family intervention.

Recordings of many of the conference sessions are available at http://www.prolibraries.com/zerotothree/?select=sessionlist&conferenceID=

References

Readynation. (2012). Readynation's mission. Retrieved from http://www.readynation.org/mission/.

Zero to Three's 27th National Training Institute. (2012). Leading-edge early childhood science, policy, and practice. [Brochure]. Washington, DC: Author.

Charlotte Savage *is a psychologist at the Department of Behavioral Health of San Bernardino County in San Bernardino, California. She works in the Centralized Children's Intensive Case Management unit with children and young adults with severe and complex behavioral and mental health issues. She was first exposed to trauma work during her internship in graduate social work in the emergency room at Texas Children's Hospital, where she worked with survivors of physical and sexual abuse and assault.*

Who's Who:
Dr. Catherine Koverola, Dean, Lesley University

Nina Kominiak, BS

Lesley University Dean, Dr. Catherine Koverola, is a highly respected psychologist in the field of trauma psychology. She has extensive experience in clinical practice, program development, research, and academic administration.

Dr. Catherine Koverola

Prior to becoming an administrator, she worked as a clinical psychologist for over two decades in places ranging from urban medical centers in Los Angeles and Baltimore to remote corners of North America such as Alaska, northern Ontario, and Manitoba. In addition to her clinical work, she maintained academic appointments in a number of university settings. Dr. Koverola has at times traveled by plane, dog sled, snow machine, canoe, and once, even a helicopter just to get to work. She was born in Canada to Finnish immigrants and has retained her fluency in this highly complex language, even giving lectures in Finnish to trauma specialists in Finland.

Dr. Koverola has worked in a variety of cross-cultural settings with populations from various ethnic backgrounds. The focus of her work has been with victims of interpersonal violence including child abuse, sexual assault, and domestic violence. In addition to providing direct care, she has been instrumental in the development of various clinical training programs and mental health programs for victims of violence. In Alaska, she was the founding director of both the Clinical-Community-Cross Cultural Doctoral Psychology Program at the University of Alaska Fairbanks as well as the Alaska Rural Behavioral Health Training Academy. In addition to her clinical work, victim advocacy, teaching, and program development, Dr. Koverola is a well-published trauma researcher whose work has been funded by the National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, and numerous private foundations.

Nina Kominiak, BS

1) What is your current occupation?

I am the Dean of the Graduate School of Arts and Social Sciences at Lesley University in Cambridge, MA. I came to Lesley two years ago from Antioch University Seattle, where I held the position of Interim Provost as well as Dean of the School of Applied Psychology, Counseling and Family Therapy.

2) Where were you educated?

My doctoral degree in Clinical Psychology is from Fuller Theological Seminary School of Psychology, where I also completed my Master's in Theology. My Master's of Arts in Psychology is from the University of Western Ontario, Canada, and my Bachelor's Degree is in Biology from the University of British Columbia, Vancouver, Canada.

3) Why did you choose this field?

As long as I can remember, I have had a desire to help people and work with children. My initial plan was to go to medical school and become a pediatrician. Along the way, I realized that psychology was more my calling. I really enjoyed a psychology course during my undergraduate studies, fell in love with the field, and found the specialty of trauma psychology in grad school.

As a clinician and clinical supervisor, I have been truly privileged to accompany victimized children, adolescents, adults, and communities along their path to wholeness. The opportunity to work with people of so many different ethnic and cultural backgrounds has also been incredibly enriching and rewarding to me personally. The resilience of the human spirit in the face of suffering never ceases to amaze me.

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

These days as a Dean, I find it very rewarding to support the talented faculty who are training the next generation of change agents in psychology, the arts, and social sciences. Today's students will be making the difference for tomorrow.

5) What is most frustrating about your work?

Sometimes there are bureaucratic barriers that prevent me from providing the best possible tools that my faculty and staff need for their job. It's frustrating to see what needs to be done and to not be able to make it happen.

6) How do you keep your life in balance?

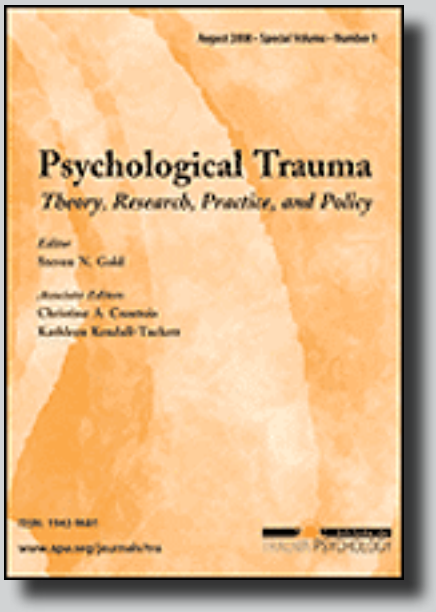
Meditation and mindfulness have been new additions to my efforts in maintaining balance, especially on hectic days. Throughout my career, I have found it crucial to be well grounded through connections with family and friends. I am eternally grateful for the support of my fun-loving Caribbean husband and daughter, who never take me seriously and ensure that I take time to play, laugh, enjoy good meals, and get enough sleep. Our little dog, Sisu, is my faithful and playful companion on daily walks.

7) What are your plans for the future?

I absolutely love the work of university administration and look forward to staying in this field. I am also committed to international trauma psychology and relentlessly continue to advocate for the importance of this field in higher education at Lesley University as well as through international affiliations. With that being said, in the distant future I see myself living under a mango tree soaking in the Caribbean sun! (Well, maybe I'll sneak in a little consulting in the field of trauma.)

Nina Kominiak, BS, *is a psychology and computer geek. Prior to shifting to psychology, she worked in the technology field for over a decade, holding positions in the US as well as overseas. However, she decided to follow her calling, and ended up studying psychology, fell in love with the field, and is getting ready for graduate studies in Cognitive Neurosciences. Currently she is doing research at UAA's Psychology Department under the Faculty members' supervision regarding military psychology as well as conditioned place preferences. She is also developing technical solutions at Apple, Inc. for people with cognitive and learning disabilities such as dyslexia, autism, and aphasia – among others.*

Call for Nominations for Journal Editor of *Psychological Trauma: Theory, Research, Practice, and Policy*



The American Psychological Association's Division of Trauma Psychology (Division 56) has opened nominations for the Editorship of *Psychological Trauma: Theory, Research, Practice, and Policy* for the years 2015-2020. This peer-reviewed, bimonthly publication focuses on empirical research on the psychological effects of trauma. The journal is considered a forum for an interdisciplinary discussion on trauma, blending science, theory, practice, and policy. Terence Keane and Kathleen Kendall-Tackett will chair the search and would like to extend their warmest appreciations to Steven Gold, PhD, who is the incumbent editor.

Candidates should be available to start receiving manuscripts in early 2014 to prepare for issues published in 2015. Please note that the APA Publications and Communications Board encourages participation by members of underrepresented groups, and therefore welcomes the nomination of members from racial/ethnic minorities, the LGBT community, and people with disabilities. Self-nominations are also encouraged.

Candidates should be nominated by accessing http://editorquest.apa.org/ and completing the electronic form. Prepared statements in support of a nominee, which must be one page or less, can also be submitted by e-mail to Rosemarie Sokol-Chang, Managing Director, at rchang@apa.org. The deadline for accepting nominations is **March 15, 2013,** when reviews will begin.

Duhigg, C. (2012). *The Power of Habit.* New York, NY: Random House. ISBN 978-1-4000-6928-6 eBook ISBN 978-0-679-60385-6 ($28.00, print; $13.99, eBook).

Serena Wadhwa, PsyD, LCPC, CADC

The Power of Habit by Charles Duhigg is an easy-to-read informational asset. He explores how habits form by providing research and case studies that indicate creating habits is one way the brain attempts to save effort. Interestingly, the basal ganglia's activity changes as a series of behaviors becomes familiar and routine, and we pay less attention to the activity that is becoming a habit. Duhigg explores how subtle behaviors, beliefs, and desired emotional states interweave to create seemingly unbreakable and unintentional patterns that, when we do become aware of them, may surprise us.

Serena Wadhwa, PsyD, LCPC, CADC

The book is divided into three parts, exploring habits in the individual, organizations, and societies. An appendix provides additional information as to how the reader may be able to apply this information to personal habits he/she wants to work on. This is a great resource that can well supplement therapy. According to Duhigg (2012),

> You must consciously accept the hard work of identifying the cues and rewards that drive the habits' routines, and find alternatives. You must know you have control and be self-conscious enough to use it—and every chapter in this book is devoted to illustrating a different aspect of why that control is real. (p. 270)

The first part explores how habits work from a neurological and behavioral perspective. Duhigg explores the behavioral sequence common for habits, that of "cue-routine-reward." What constitutes a cue, a routine, or a reward is so individual, that there is not a cookie cutter approach that applies to everyone. The author provides some practical advice, such as figuring out what specific cues are reinforcing the habit. For example, with a nail biter, the "cue" was identified as tension in the fingertips. When the client experienced this tension, she bit at her nails, and the reward was the physical stimulation. Additionally, the first part explores how we can create a habit by making the brain want what we are trying to offer, which varies from person to person. We can "make" the brain desire and expect something (the reward) a behavior may produce (cue and routine), and thus, influence and create a habit. This is also what Duhigg discusses in terms of transforming habits we want to change: We want the same reward, but how we go about getting it can be altered into more desirable behavior. He provides illustrations of these different pieces of the process. He also goes on to explore how it is not only the behaviors that need to be attended to, but also how beliefs interweaved with the creation of changing habits. Drawing on Alcoholics Anonymous and football coaching, Duhigg provides some great examples of how believing in something, especially during times of duress, is an important coping mechanism.

In the second part of the book, Duhigg explores how habits affect organizations and how certain habits at big organizations trickle into other areas of the organizations' and employees' lives. Mental, behavioral, and emotional factors could initiate bigger changes in organizational policies and procedures. In some respects, when these habits develop, they can also influence the values the "community" holds and lives by. Some of these "keystone habits" create other habits. In an organization, this process may contribute to its success. There are several examples Duhigg provides that explore these concepts in more detail, including the habits of an Olympic Gold winner. The section also examines how willpower is not merely a skill, but a muscle to be strengthened. He suggests that willpower can be taught to individuals as a way of cultivating success through taking baby steps. The author provided information on how to deal with cues that may be tempting to spin us back to habits we are trying to change. In many ways, this creates a sense of choice, which allows an individual to believe they have some control, a powerful cue and reward. This section also covers how habits are used in the marketing and advertising of products.

In the last section, Duhigg discusses how habits play a role in societies as well, through examining peer pressure as a powerful influence in moving friends and acquaintances to create massive changes. He explores how, in part, our social habits can influence movements, and illustrates his point with Rosa Parks and the civil rights movement.

Finally, Duhigg explores our own responsibility for our habits by examining the neurological basis of habits. He contrasts sleep terrors with gambling and explores how the awareness of cues, routines, and rewards, and the patterns of certain behaviors we pay attention to, are habits we then have the responsibility

and ability to change. The appendix provides a way of understanding one's habits and what to look for in understanding one's own breakdown of habits. Duhigg is adamant, and rightfully so, in stressing that habits differ for each person, as do the motivations, needs, and rewards.

This book is a valuable tool for anyone who wants to understand habits and work on changing them. Its easy-to-read format makes it available and inviting to anyone. Clinicians will find this book a useful tool to illustrate how cues, routines, and rewards can vary from individual to individual and how these processes can be experimented with to facilitate change.

Serena Wadhwa, PsyD, LCPC, CADC, *is an assistant professor in the Addictions Studies Department at Governors State University. She also provides individual therapy at the Alexian Brothers Outpatient Group Practice. She also blogs for ChicagoNow. She specializes in addictions/recovery and stress empowerment and balances her time among work, fun, family, friends, and self.*

Palmer, L. (2012). *The PTSD Workbook for Teens.* Oakland, CA: New Harbinger Publications, Inc. (160 pp). ISBN 978-1-60882-321-5

Cheryl B. Sawyer, EdD

Libbi Palmer's *The PTSD Workbook for Teens* (2012) provides a workbook-based journey towards healing for teenagers who have experienced a traumatic event. Based on Cognitive-Behavioral Therapy, this workbook facilitates a self-paced process.

Cheryl B. Sawyer, EdD

In the preface, Palmer offers a gentle letter of support for traumatized teens, encouraging them to explore the painful experience through a safe, sequential journey. While acknowledging that teens could choose to complete this workbook independently, the author also suggests sharing the contents with other people such as a mental health professional. An accompanying letter to parents provides insight to guide parents in supporting their children through a traumatic experience.

This book is well structured and written in basic, age-appropriate vocabulary without the use of jargon or cliché. Each of the 39 chapters opens with basic information followed by several short examples applying the concepts to specific life situations. One to five pages of activities conclude each chapter and provide opportunities for teens to reflect on past actions, create plans, and decide on healthy choices. Open-ended journal questions, checklists, charts, and physical activities provide the opportunity to self-process the content and apply this knowledge to personal experience.

The majority of the chapters focus on helping teens prepare to tell their story. These chapters, based on trauma theory and best practices, include building a safe space for exploration, understanding the physiological and emotional impact of trauma on the body and mind, common relaxation activities, and suggestions for remaining in the here-and-now as teens explore their traumatic past. Teens are empowered by visually acknowledging the new knowledge and skills via checklists prior to venturing into the painful experience of telling their story. The actual "Telling of the Trauma Story" (chapters 31-33) is accompanied by activities that ask teens to acknowledge thoughts, feelings, and sensory elements. The book concludes with several chapters geared toward helping teens grasp that healing from a traumatic experience can be an evolving, lifelong process.

The back cover presents this book as an Instant Help Book, a division of New Harbinger Publications, Inc. In my opinion, it is dubious that this book can provide either Instant Help or that any teen would independently devote the time and energy necessary to complete each sequential activity. Most likely, a teenager might receive this book from a well-intentioned friend or relative with hopes that thumbing through the text would stimulate interest in participating in therapy. Teenagers tend to be reticent towards sharing with adults what they perceive to be inadequacies, shameful experiences, or inability to cope. Perhaps the biggest strength of this book is that it can help a teenager view the journey of self-healing from a non-threatening perspective and come to believe in the possibility of a positive conclusion, thus potentially relieving fears associated with working with a clinician.

The title, *The PTSD Workbook for Teens,* clearly suggests that this book is designed for those with Post Traumatic Stress Disorder (PTSD). Because each person experiences trauma differently, it would be inappropriate to suggest that this workbook would have little value as a self-help book. However, I believe it would be risky to encourage such use of this book without the supervision of a therapist well-

versed in working with adolescents who have PTSD. Developmental theory suggests that teens can be impulsive, moody, labile, and unpredictable; teens using denial or repression as coping strategies can rapidly become emotionally volatile as traumatic memories surface.

This book could be a strong tool to use in conjunction with therapy with a mental health provider. It is well organized, well written, theoretically based, and promotes activities based in best practices. The structured content is highly appropriate for use with teenagers, who are used to gaining knowledge from a book in school. Therapists could use chapters as topics with verbal discussion stemming from the essay-type questions. The charts and lists could serve as homework, thus providing reinforcement for previous therapy sessions and preparation for future sessions. Many of the activities provide short yet safe glimpses into the teens' own world and are most likely innocuous as self-exploration tools. The therapist could determine if skipping chapters would be appropriate or if any area needed more exploration than presented in the workbook. Information exchange and sharing within a teen-based group therapy setting could be greatly enhanced by relying on the structure and sequential progression provided by this book.

Cheryl B. Sawyer, EdD, *is an Associate Professor of Counseling and Coordinator of the Counseling Program at the University of Houston Clear Lake, and specializes in working with traumatized or abused children/teens. She has more than 35 years of experience in working with children and teens as a teacher, school counselor, licensed specialist in school psychology, and counselor educator. Dr. Sawyer also is a volunteer member of the Galveston County Child Services Board and Mental Health Coordinator for Texas Bikers Against Child Abuse.*■

Spring/Summer 2013 *TPN:* Call for Articles and Special Note

Trauma Psychology Newsletter is now accepting submissions for the **Spring/Summer 2013** 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. **The deadline is April 15, 2013.** Please limit length to 1,500-2,000 words, and send in MS Word or WordPerfect formats using APA Style. Please include a 100-word author bio at the end of the article and send a high-quality photo (jpg or tiff) with your submission. Article submissions or requests for full editorial guidelines should be sent to Simon A. Rego, PsyD, Editor (srego@montefiore.org) and Renu Aldrich, MFTi, Associate Editor, (renu@renualdrich.com).

Simon A. Rego, PsyD

Renu Aldrich, MFTi

Special note: We are pleased to announce that the Spring/Summer 2013 issue will feature a **special section** on trauma and military veterans to mark the 10th anniversary of the start of the wars in Iraq and Afghanistan. It will be guest edited by **Drs. Sonja Batten and Paula Schnurr.** Dr. Batten is the Deputy Chief Consultant for Specialty Mental Health (which includes PTSD) for the U.S. Department of Veterans Affairs, and Dr. Schnurr is the Deputy Executive Director of the VA's National Center for PTSD. The section will include articles from a range of experts addressing topics on trauma and PTSD that affect military veterans, including gender differences, military sexual trauma, comorbidity, and aging. Other articles will describe how the VA is implementing evidence-based treatment and using innovative technological strategies to enhance care.

WHO WILL PAY THE BILLS?

Group Income Protection Insurance through The Trust is the simple, affordable answer.

Think about how many people you care for… in your business, in your community, and especially at home. How would your family continue to get by if you suddenly lost your earning power due to a debilitating illness or injury? The Trust Income Protection (disability income) plans are the affordable answer.

Our plans* are designed to provide you with income in the event of total disability, and you can choose the benefits and features that best suit your personal needs.

Learn more about protecting your earning power at www.apait.org or simply call us at 1-800-477-1200 for a no-obligation consultation. We'll show you how protecting yourself today may save you and your family so much trouble and expense tomorrow.

THE TRUST

www.apait.org • 1-800-477-1200

---

* Coverage is individually underwritten. Policies issued by Liberty Life Assurance Company of Boston, a member of Liberty Mutual Group. Plans have limitations and exclusions. For costs and complete details, call The Trust or visit www.apait.org.

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 trauma and disaster in its scientific, professional, educational, and public policy aspects. The Division also helps to advance scientifc 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, *Psychological Trauma: Theory, Research, Practice, and Policy,* at the member rate of $21.50 per year. You do not need to separately subscribe to receive this journal; just be sure that your dues are paid up 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 the US/Canada) or order online and provide the code # TPD20.

DIVISION 56
TRAUMA PSYCHOLOGY
AMERICAN PSYCHOLOGICAL ASSOCIATION

Join Division 56 Now!

Membership Category	Rate	Journal
☐APA Associate, Member, Fellow	$45.00	Included
☐Professional Affiliate	$45.00	Included
☐Early Career Psychologist	$35.00	Included
☐First year APAGS	Free	$21.50
☐Student	$10.00	$21.50

Name _____

Address _____

City _____

State _____ Postal Code _____

Phone _____

Email _____

APA Membership Number _____

Make check payable to Division 56 or complete the following to pay with credit card:

☐Mastercard ☐Visa ☐American Express

Card Number _____

Expiration Date _____

Name of Cardholder _____

Credit Card Billing Address _____

City _____

State _____ Postal Code _____

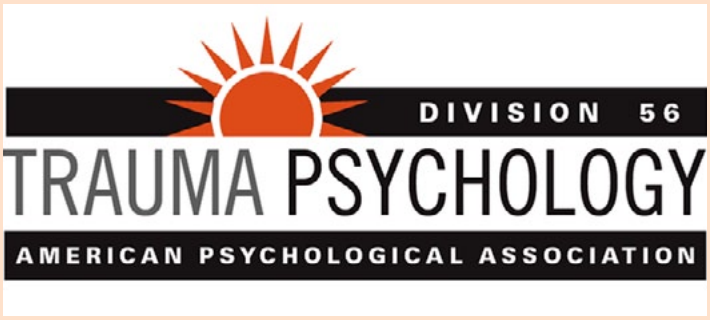
Amount _____

Signature _____

Mail form to:
Division 56 Administrative Offce
American Psychological Associaiton
750 First Street, NE
Washington, DC 20002-4242

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

EDITORIAL STAFF



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

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

Editorial correspondence and submissions (< 3,000 words) are welcomed and appreciated. Please submit articles and references in APA style and send, via e-mail, as an attachment in Word format, to the Editor exactly as you wish it to appear. With their submissions, authors should also include a brief author statement, contact info, and self-photo for publication use.

PUBLICATION SCHEDULE AND SUBMISSION DEADLINES

Authors' Submission Deadline	Issue	Publication Date
January 15	Winter	February
April 15	Spring/Summer	May
September 15	Fall	October

ACCURACY OF CONTENT AND COPY INFORMATION

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

ADVERTISING POLICY, RATES, AND QUERIES

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

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

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

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

DIVISION 56 LOGO INFORMATION

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