



DIVISION 56

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

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PRESIDENTIAL VOICE

Let's Join Together

Dear Colleagues,

The revelations, by David Hoffman and his staff, about the betrayal of trust by some of our most senior APA leaders, have shaken us to our core. At the same time, these revelations have brought home to us the social science research by outstanding social psychologists, primarily of the 20th century: Stanley Milgram, David Rosenhan, Phil Zimbardo, Henri Tajfel, Irving Janis.

What have these social scientists taught us about human nature? That we trust our leaders; that the higher their status and the greater their attractiveness, the more we trust them and the more “obedient” we are. That we all engage in “groupthink” or the desire to minimize conflict by moving toward a consensus decision, refusing to consider alternative viewpoints; discouraging and disparaging dissent; and isolating ourselves from other viewpoints. That explicit power differentials in groups foster an

“us” vs. “them” mentality, triggering a sense of profound “depersonalization” in the less powerful group.

Many of us, in our disbelief, anger, humiliation, and sadness, have responded to our institutional crisis with sharp denunciations of the institution that failed us, as well as of the individuals who made errors in judgment, some of the most egregious of which are irreparable and bolstered an inhumane national policy on torture.



Beth Rom-Rymer, Ph.D.

While it has been critical to sever ties with some of our APA leaders for actions (or inaction) that led us down a very destructive path, it is

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Who's Who

Turn to p. 20 to learn more about Editor Bryan Reuther

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Presidential Voice

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just as important to see some of them, as well as others, as having human frailties, just like us. Statements have been made that only bad people do bad things or make serious errors in judgment. Our venerable social science researchers have taught us differently.

Who are we if not a community of flawed human beings? Who among us has not succumbed to error and poor judgment? Who among us can say that s/he has not sinned?

Do we throw our colleagues to the lions or march them to the guillotine? And how many colleagues do we purge?

Or do we come together as a community of psychologists to seriously examine the factors that contributed to our pursuing a path that veered dangerously away from our stated mission? And shall we instead forge a purposeful plan that could protect our members and our Association from falling into the same abyss?

We psychologists are well known for our passion for learning. Why not use our Convention programming to sharpen our skills in critical, outside the box, discordant, and, if necessary, disruptive thinking?

Let's learn from this failure. Indeed, let's join together to become better at seeing other perspectives, hearing dissenting views, and integrating dissonant chords into our own thinking.

Division 56 Convention

In planning our Convention 2015, we had no premonitions of the catastrophic events that would befall our Association. But because of Division 56's fundamental commitment to human rights, we themed our Convention: "Trauma and Social Justice."

I encourage each of you to join us for our many events that touch on the multiple traumas that have been engulfing the larger world as well as our own Association. Our program includes a special 2-hour session to discuss the APA crisis, on Saturday, August 8th, from 2:30-4:30, in our division Suite (the Harbour Suite) at The Westin Harbour Castle Hotel.

Our symposia titles include:

1. The Impact of Institutional Betrayal Resulting from Law Enforcement Perpetrated Violence, chaired by Sandra Mattar
2. Institutional Betrayal and Health, chaired by Bridget Klest

3. PTSD Among Military Families, chaired by Terry Keane
4. Frodo and Sam Enter Mordor: The Feminist Therapy Alliance in Complex Trauma, with Laura Brown and Victoria Harris
5. Theoretically-Driven Approaches to Reducing Interpersonal Violence among Youth and Young Adults, chaired by Lindsey Orchowski
6. Race and Trauma Knowledge in Treatment and Research, chaired by Constance Dalenberg
7. The Heavy Burden of Child Maltreatment: A Needed Dimensional and Developmentally Sensitive Approach, chaired by Constance Dalenberg
8. Trauma and Recovery among Diverse Survivors of Violence against Women, chaired by Thema Bryant-Davis
9. Violence and Social Justice: Women's Perspectives from Africa, Prison, and Social Media, chaired by Ani Kalayjian
10. The Trauma of Incarceration, chaired by Nnamdi Pole and Beth Rom-Rymer
11. Promises and Pitfalls of Online Interventions for Traumatized Individuals: Results of Empirical Evaluation, chaired by Heather Littleton
12. Historical Trauma: The View Through Different Cultural Lenses, chaired by Nnamdi Pole, with special guest, Rachel Yehuda
13. So, You Want to Pass a Law? How Psychologists can Inform Public Policy at Local, State, and Federal Levels, chaired by Dan Grech

We are most honored to have as our keynote speakers:

1. Internationally renowned psychologist, Stevan Hobfoll, whose talk is entitled: "Caravan Passageways and the Creation of Trauma Resilience"
2. Bryan Stevenson, J.D., whose recent book, *Just Mercy*, a memoir that personalizes the struggle that Mr. Stevenson has undertaken against a highly discriminatory and unjust Criminal Justice System, is a New York Times bestseller. Division President Beth Rom-Rymer will be giving Mr. Stevenson the Division 56 Presidential Award for Social Justice.

In addition, we are holding many special events in our Division 56 Suite (The Harbour Suite) in the Westin Harbour Castle Hotel:

1. Black Lives within the Criminal Justice System: Implications for Clinical Practice, chaired by Nnamdi Pole and Amber Douglas
2. The Future of Practice, chaired by Amy Ellis, Bryan Reuther, and Vanessa Simiola
3. How to Teach a Trauma Course, chaired by Janna Henning and Jessica Punzo
4. Getting Published, chaired by Kathy Kendall-Tackett
5. "Am I Cut Out for This?" An Honest Discussion with Psychologists about Self-Care and Building Resil-

ience, chaired by Charles Figley and Kathy Figley

6. Student/ECP/Senior Psychologist Mixer

As noted above, we are holding the special two-hour session, to discuss the APA Crisis, in our Division 56 Suite on Saturday, August 8th, from 2:30-4:30, chaired by Division President Beth Rom-Rymer.

Please go to www.apatraumadivision.org for the full Convention programming schedule.

In this challenging time, I look very much forward to our coming together to process the recent catastrophic events and to start rebuilding our future. We can do better and I believe that we will.

Beth N. Rom-Rymer, Ph.D.
President, Division 56

Moving Forward



Bryan T. Reuther, Psy.D.
Editor-in-Chief



Tyson Bailey, Psy.D.
Associate Editor

Dear Colleagues,

We are well into summer, and with that brings the pre-convention issue of *Trauma Psychology News*. It is with great honor that I am now part of this publication as Editor-in-Chief, and I would like to express my appreciation for the fine work of my predecessor, Renu Aldrich. In addition, this publication would not be possible if it was not for the hard work my staff, especially my Associate Editor Tyson Bailey, Keith Cooke at Divisions Services, Division 56 leadership, and the superb contributions by our members.

As most of us are finalizing our plans and presentations for the upcoming convention, or perhaps just going about the day-to-day, it may be under difficult and unnerving circumstances. The Hoffman Report has revealed information that has forced us to take a serious look at the APA—and ourselves. Perhaps there are more questions than answers, and as we all know, the “whys” are often

the most difficult. Nevertheless, our Division 56 president Beth Rom-Rhymer’s Presidential Voice in this issue provides an honest and thoughtful look at what has happened, and I hope you consider her words in your own process. This is a time of reflection and refocus.

However, I do not want to let the current circumstances overshadow the incredible work that our members do every day, and the convention program. This issue is but a snapshot of some of great work. I encourage you to take a look at our wonderful presentations planned this year, and in particular, our hospitality suite program (pp. 6-7). Looking forward to seeing many of you at the convention!

All the Best,

Bryan T. Reuther, PsyD
Editor-in-Chief

APA Division 56

2015 Convention Programming

By Nnamdi Pole, Ph.D

The Trauma Division (Division 56) has been working hard all year to develop an exciting program of symposia, suite events, and posters. Here is a brief summary of what we have in store for you.

Conference Themes. The overarching theme of this year's programming is "Trauma and Social Justice" with a particular eye toward the issue of racial disparities within the criminal justice system. Other subthemes are apparent in our formal programming through symposia that are clustered around similar topics such as: institutional betrayal trauma, violence against women and children, culture and racism, and posttraumatic growth.

Featured Speakers. We are thrilled to have attracted Bryan Stevenson, JD as our keynote speaker and recipient of the Presidential Award for Social Justice. Bryan Stevenson has been eagerly sought after by a number of media outlets for his outstanding work on racial disparities in mass incarceration (e.g., TED talks, 60 Minutes, and Meet the Press; https://www.ted.com/talks/bryan_stevenson_we_need_to_talk_about_an_injustice). Come see what the fuss is about! We are also featuring a keynote address by renowned trauma expert, Steven Hobfoll, Ph.D., entitled "Caravan Passageways and the Creation of Trauma Resilience" which is certain to advance our thinking about how to stay strong in the face of trauma. In addition, we are delighted to announce that Rachel Yehuda, Ph.D., will present on part of a symposium entitled "Historical Trauma: The View Through Different Cultural Lenses." Rachel is a world expert on the biology of trauma and she will apply her expertise to the interesting question of transgenerational transmission of trauma in descendants of Holocaust survivors. Finally, Division President Beth Rom-Rymer, Ph.D. will lead a symposium on translating the social justice themes of the conference into legislative action.

Symposia. Division 56 is proud to be part of two exciting collaborative symposia. One is entitled "Exploring future directions for PTSD research in military populations" and the other is entitled "The seriously mentally ill: Perpetrators of violence or victims of suicide and violence?" In addition to the symposia on historical trauma



Namdi Pole, Ph.D.

and legislative action, our formal programming includes 14 other symposia addressing topics such as: contemporary issues regarding the trauma of mass incarceration, PTSD in military families, institutional betrayal in law enforcement and health care, child maltreatment, interpersonal violence, feminist psychotherapy for complex trauma, online trauma interventions, and posttraumatic growth among health care professionals. These symposia will feature well known trauma experts such as: Laura Brown, Terry Keane, Jennifer Freyd, Constance Dalenberg, Kathleen Kendall-Tackett, Heather Littleton, Joseph Gone, Thema-Bryant Davis, Diane Elmore, and Richard Tedeschi.

Posters. On top of all of this we are pleased to feature close to 80 trauma-oriented posters that will be presented on Friday and Sunday mornings. These posters will address a rich diversity of topics including: mediators of the relationship between child abuse and interpersonal problems, posttraumatic growth in U.S. military veterans, emotion dysregulation and PTSD symptoms, PTSD among incarcerated veterans, posttraumatic stress among journalists, yoga treatment for women with chronic PTSD, personality and PTSD among cancer patients, child abuse and eating disorders, moderators of PTSD in homeless people, informed consent in trauma research, rethinking PTSD in refugees and torture survivors, and testing the trauma and fantasy models of dissociation.

Suite Events. Finally, we are pleased to be hosting a number of informal events in the Division's beautiful and spacious hospitality suite, The Harbour Suite at the Westin Harbour Castle Hotel. These events include: our division Business Meeting, a social mixer for junior and senior professionals, conversation hours about the formal programming and a series of conversation hours focused on Black lives within the criminal justice system, the future of practice, how to teach a trauma course, getting published, self care and building resilience. Please drop by, enjoy a glass of wine, and stay a while!

Nnamdi Pole, Ph.D. is the 2015 Convention Programming Chair for Division 56. He is also a Professor of Psychology at Smith College and a licensed clinical psychologist. His areas of expertise include the psychophysiology of trauma disorders and ethnocultural variation in traumatic stress.

Hospitality Suite Programming



Our hospitality suite in Toronto is the spectacular Harbor Suite in the Westin Harbor Castle! Please think of our Division 56 suite, with its ample space and breathtaking views, as your “home away from home” while at our 2015 Convention. In addition to our specifically scheduled events in the suite (see below), our suite will also be open to you, our Division members, from 10AM-9PM each day to drop in as you please. Space is also available for small division-focused meetings, with approval from our suite coordinator, Jessica Punzo. Light food and drinks will be provided during our scheduled events. We look very much forward to your spending time with us in our beautiful home during your stay in Toronto!

Thursday 8/6/2015

5:00-6:00 PM

*Black Lives Within the Criminal Justice System:
Implications for Clinical Practice*
Nnamdi Pole, Ph.D. & Amber Douglas, Ph.D.

Recent years have brought a large number of highly publicized accounts of the violent deaths of unarmed African American men. These events have been accompanied by social outrage and allegations of criminal injustice by numerous segments of the criminal justice system, including the police and the courts. Given this year’s Division 56 conference theme of “Trauma and Social Justice” and our formal programming that addresses these issues, we thought it appropriate to provide a conversation hour to discuss how these horrific events,

reported so widely in the media, may be impacting our clinical work. In this discussion hour, we will talk about how to raise these events for discussion with our clients and how to address the implications of these events when brought in to session by our clients. Nnamdi Pole and Amber Douglas both have expertise in African American Psychology and Trauma Psychology. They will provide a forum for conversation, shared experience, and good counsel.

6:00-7:00 PM

The Future of Practice
Amy Ellis, Ph.D., Bryan T. Reuther, Psy.D. & Vanessa Simiola, M.A.

The future of trauma practice is progressively moving towards integrating healthcare to provide comprehensive, multidisciplinary, evidence-based treatment that can target both medical and psychological sequelae. This workshop will provide information for early career psychologists interested in opportunities for trauma practice outside of traditional domains, to include a myriad of healthcare settings (e.g., hospitals, colleges/universities, rehabilitation centers). Current evidence-based research and standards of care in treating trauma, from a collaborative interdisciplinary approach, will be presented. Discussion points will center around maintaining one’s role in working with various disciplines, prescriptive privileges, systemic challenges and barriers to treatment, advocacy efforts in advancing psychologist’s role in integrated care, and navigating social justice issues that arise in working with survivors of trauma.

7:00-9:00 PM

Evening Soirée with Presenters

Were you particularly moved or intrigued by the symposia that you attended earlier in the day? Would you like an opportunity to talk further with the presenters? At our evening soirée, you can! Join us in our suite to talk with our presenters and other division members on a more intimate level.

Friday 8/7/2015

12:30-2:30 PM

How to Teach a Trauma Course

Janna Henning, Psy.D & Jessica Punzo, Psy.D.

Back by popular demand! The content of trauma psychology in psychology curricula is one of utmost importance. Dr. Jessica Punzo will provide preliminary findings on the research being done by Dr. Bethany Brand and her colleagues on trauma psychology content in undergraduate and graduate level textbooks. Dr. Janna Henning will present on her development of the Traumatic Stress Concentration and trauma focused courses within the Psy.D. program at Adler University. This discussion is intended for professors who currently teach trauma psychology and those wishing to learn how to create a course. We will be reviewing various trauma course syllabi from professors around the country both in graduate and undergraduate institutions.

2:30-3:30 PM

Getting Published

Kathleen Kendall-Tackett, Ph.D.

Publications are key to professional success. Yet, most graduate students never learn even the basics of the publication process. Dr. Kathleen Kendall-Tackett, the current Editor-in-Chief of Psychological Trauma (Division 56 APA journal) will be presenting on the tricks of the trade of publishing and how to increase your chances of success. Dr. Kendall-Tackett is also the Editor-in-Chief of the U.S. Lactation Consultant Association journal, Clinical Lactation, and has authored or edited nearly 400 articles or book chapters and 29 books and monographs.

Saturday 8/8/2015

3:30-5:00 PM

Afternoon Soirée with Presenters

Were you particularly moved or intrigued by the symposia that you attended earlier in the day? Would you like an opportunity to talk further with the presenters? At our afternoon soirée, you can! Join us in our suite to talk

with our presenters and other division members on a more intimate level.

5:00-6:00 PM

"Am I Cut Out For This?"

An Honest Discussion with Psychologists About Self Care and Building Resilience

Charles Figley, Ph.D. & Kathy Figley, Ph.D.

Experienced psychologists have faced the challenges of managing their profession's stress and have come out the other side. Work-Life balance has become a finely-tuned art. Psychologists practicing 10 years or more have begun to develop effective balancing strategies to ensure that their work does not take over their lives. Early career psychologists, on the other hand, are just beginning their journey. How do early career psychologists maintain that freshness and build upon it? How do they build a self-care plan and develop resilience to profession-related stress and adversity?

Psychologists Charles Figley and Kathy Regan Figley will lead a discussion about psychologists' personal and professional lives: the biggest challenges to self-care and building resilience to adversity. Building on last year's APA 2014 discussion, the Figleys will first ask veteran psychologists to share the strategies that they have mastered for balancing work and personal life; overcoming insecurities in the face of challenging work situations and clients; and acquiring the wisdom to recognize their limitations without a loss of confidence.

Next, Drs. Figley talk with early career psychologists about their mad dash to acquire the necessary credentials, experience, and connections for pursuing their ideal job. The final segment engages the audience in sharing ways of becoming successful and personally satisfied professionals by building resilience to the pain and suffering of our clients; to the pitfalls of "office politics;" to the craters in the road while traveling toward the next ambitious professional goals; and to the tedium of mundane, repetitive tasks. Come join us for this fascinating program!

6:00-8:00 PM

Student/ECP/Senior Psychologist Mixer

By far, one of our most popular and fun events at every Convention! This is a Division 56 social event for students, ECPs, mid-level, and senior psychologists, giving everyone time to mingle and to get to know each other better. Students and ECPs will talk with distinguished and accomplished senior psychologists and find abundant mentoring opportunities focusing on all aspects of career building: teaching and research trajectories; organizational administrative building blocks; clinical paths; and so much more!

STAIR Narrative Therapy: A Brief Overview of Rationale, Treatment Characteristics, and Efficacy

By Marylene Cloitre, PhD

Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy (citation) is an evidence-based psychosocial treatment organized into two modules. In the first module, emotion regulation and social/relationship skills are taught and practiced; in the second module, trauma-focused work is introduced as skills practice continues. The treatment was initially developed for adults with Posttraumatic Stress Disorder (PTSD) who had experienced childhood abuse. The purpose of the treatment was two-fold: to address the resolution of PTSD symptoms through trauma-focused work, and to provide dedicated time and attention to relationship and mood management problems.

The motivation for the development of a treatment focused on the latter issues was straightforward: patients asked for help in these domains. A study summarizing the presenting problems of the first 98 patients assessed in our trauma clinic in New York City indicated that problems related to PTSD symptoms ranked third in frequency after problems with relationships, and with emotion management problems as reflected in difficulties with anxiety and depression, with managing suicidal feelings and with drug use (Levitt & Cloitre, 2005). We paid attention to the patients' requests and investigated the degree to which such problems had an impact on functioning. An investigation of predictors of functional impairment indicated that, of the total variance accounting for problems in overall functioning, PTSD symptoms accounted for only 50% percent; an additional 50% of the variance was accounted for by relationship problems and emotion regulation difficulties (Cloitre, Miranda, Stovall-McClough, & Han, 2005). This finding consolidated an initial commitment to develop a treatment that included interventions directly addressing these difficulties, along with more traditional trauma-focused work.

Delivered in individual format, the first phase of treatment, STAIR, is typically comprised of 8 sessions. The first session provides psychoeducation about the impact of trauma on emotion regulation and relational capacities and, more specifically, focuses on identifying the client's specific problems in these areas. The development of a personalized treatment plan is intended to strengthen client engagement and commitment. There

are several emotion regulation strategies available for use, and the therapist selects the skills that will be practiced in collaboration with the client. The treatment organizes the emotion regulation strategies according to the traditional "three channels" of cognitive behavioral therapy (CBT), namely body-based, cognitive, and behavioral interventions. The client learns at least one emotion regulation strategy for each channel, but often more than one per channel. STAIR is implemented using a strength-based approach in which the first intervention selected builds on current strengths rather than attending to weaknesses. This strategy is consistent with recent findings from the depression literature, which indicate that the use of skills interventions that capitalize on strengths rather than compensate for deficits produces better outcome (Cheavens, Strunk, Lazarus, & Goldstein, 2012).



Marylene Cloitre, PhD

Interpersonal skills training focuses on three areas: assertiveness training, sensitivity to power structure and processes, and increasing flexibility regarding interpersonal expectations

and behaviors. One goal of the interpersonal work is to introduce the client to new ways of thinking, feeling and acting in relationships; the second goal is to help the client use these skills so that the newly learned behaviors are appropriate to a particular relationship or social context. Many survivors of repeated interpersonal violence are stuck in rigid and extreme ways of thinking and behaving in relationships. We have learned that, over time, clients can take on new social and interpersonal behaviors but their general interpersonal style stays the same—namely, rigid and extreme. Thus, a client may move from passive and submissive behaviors to extreme and overly-generalized assertive behaviors. One of the key interpersonal goals of the treatment is to help the client learn that different actions and reactions are called for in different social contexts and different relationships. The interventions involve a significant amount of in-session role play and practice between sessions to increase mastery of selected interpersonal behaviors. Interpersonal flexibility takes time, perhaps years, to master. The most important goal in the treatment is to introduce awareness of the importance of interpersonal flexibility for effective living. Clients frequently begin the treatment assuming there is a "right way" to behave with others. The treatment provides the awareness or insight that there is a range of ap-

propriate behaviors, from expressing justified anger to apologizing for a mistake.

The implementation of imaginal exposure introduced in the second half of the treatment is similar in structure to prolonged exposure (PE) (see Cloitre, Cohen, & Koenen, 2006). However, differences from PE include an emphasis on meaning analysis about interpersonal beliefs embedded in the narrative, contrasting them with the alternative and experientially tested beliefs generated during the STAIR module. In addition, because these trauma survivors have typically experienced multiple exposures to violence, the meaning analysis explicitly includes the identification of interpersonal beliefs across the traumas that have occurred throughout the lifespan.

The treatment can be flexibly applied so that the number of sessions on emotion regulation, interpersonal skills and narrative work are tailored to the clients' needs. An investigation of the flexible use of the treatment—with respect to the number of emotion regulation, interpersonal and narrative sessions—found that flexible application of the protocol produced outcomes equivalent to those obtained in an RCT in which strict adherence to the protocol was implemented (Levitt, Malta, Martin, Davis, & Cloitre, 2007). These findings led to a current study, funded by NIMH, in which STAIR Narrative Therapy is being implemented among women with PTSD related to interpersonal violence who are obtaining services in public sector settings. In this study, therapists are encouraged to apply the treatment in a way that is tailored to clients' needs. One goal of the study is to look at treatment outcomes, and to work backwards from the outcomes to identify implementation patterns associated with good, poor, and no-change outcomes, controlling for baseline characteristics.

STAIR Narrative Therapy was initially developed for individuals with chronic and early life trauma. However, it has become apparent that problems with emotion regulation and social connection occur across a wide range of traumatized populations, not just among childhood abuse survivors. A study of 9/11-exposed individuals found that, similar to an earlier study of childhood abuse survivors, emotion regulation and social problems, along with PTSD symptoms, were significant predictors of impaired functioning (Malta, Levitt, Martin, Davis, & Cloitre, 2009), suggesting the benefit of addressing these issues in populations other than those who have experienced childhood abuse. In addition, emotion management and social support have been identified as important personal and environmental resources that facilitate PTSD recovery and protect against its development (Charuvastra & Cloitre, 2008), suggesting the value of providing skills training programs to strengthen these capacities, in the service of protecting against negative outcomes in the face of future traumas and facilitating recovery if symptoms develop.

We have begun testing STAIR alone (i.e., skills train-

ing only) in group modality to assess both its potential for resilience building and as a stand-alone treatment for PTSD symptom reduction. Results thus far are encouraging. Clinical trials on group STAIR have reported significant improvements in PTSD symptoms, as well as in emotion regulation and social engagement behaviors in inpatient adult PTSD populations with comorbid schizoaffective disorders (Trappler & Newville, 2007), as well as among inpatient and outpatient adolescents with a range of traumas (Gudiño et al., 2014; Gudiño, Leonard, & Cloitre, 2015). The use of group STAIR is now being tested among veterans, as a means to increase social engagement and to encourage veterans to transition to trauma-focused interventions if they have not already received such treatments.

The efficacy of STAIR Narrative Therapy has been evaluated in six published investigations. Two studies are randomized controlled studies applying STAIR Narrative Therapy to women with PTSD related to childhood abuse (Cloitre, Koenen, Cohen, & Han, 2002; Cloitre et al., 2010); a third study used a benchmark design which identified the value of flexible application of the STAIR Narrative Therapy with 9/11 survivors; and the fourth was a comparison study reporting on the greater efficacy of group STAIR versus group treatment-as-usual in an inpatient setting (Trappler & Newville, 2007). All studies found that STAIR Narrative Therapy was effective in reducing PTSD symptoms while also improving emotion management and social functioning. The remaining two studies evaluated group STAIR among adolescents, in which group STAIR was associated with decreased PTSD symptoms as well as improved resiliency resources such as coping efficacy, sense of mastery, and perceptions of positive social engagement (Gudiño, Leonard, & Cloitre, 2015; Gudiño et al., 2014).

Overall, STAIR Narrative Therapy is an efficacious intervention for PTSD as well as a treatment that builds important resources for effective living. There are now a number of effective PTSD treatments available (see Schnyder & Cloitre, 2015), offering clinicians and patients several options from which to choose. Important next steps will involve matching treatments that have high engagement qualities and that provide optimal outcomes to client needs.

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Division 56 Listservs

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

div56@lists.apa.org

for discussion among members

div56childtrauma@lists.apa.org

for child trauma topics

div56dissociation@lists.apa.org

for post-traumatic dissociative mechanisms development

div56ecpn@lists.apa.org

for early career psychologists networking

div56stu@lists.apa.org

for student forum

Mission of the Committee

By Elizabeth Carll, PhD, Chair

The mission of the International Committee is to insure that international issues are represented in Division business and policies and to foster international collaboration and communication concerning trauma related issues.

One of the initiatives of the Committee is the series of interviews conducted by student members with trauma psychologists residing in various parts of the world. Previous interviews have been with trauma psychologists from Africa, Asia, Australia, and Europe. If you would like to recommend a trauma psychologist residing outside of the U.S. to be interviewed by a student member of the committee, please contact Elizabeth Carll, PhD at ecarll@optonline.net. These interviews give an opportunity for graduate student interviewers to connect with international trauma psychologists and simultaneously provide a glimpse into the work of psychologists residing in other parts of the world.

To encourage participation of international students at the APA convention, Division 56 offers a \$500 International Student Travel Stipend and complimentary convention registration to support travel. A free one year membership in Division 56 is also included. The recipient of the 2015 Division 56 Student travel stipend is Claudine Anderson from Kingston, Jamaica. She is a doctoral student in Counseling Psychology at Georgia

State University and received a Masters Degree from University of West Indies in Kingston, Jamaica. She is co-chairing a discussion/symposium session on "Community Violence and Jamaican Children living in the Inner-City: Treatment Implications" at the 2015 APA

Convention, which will explore how inner-city life predisposes Jamaican children to community violence and the negative consequences of such exposure. Psychological implications and resiliency processes will be discussed. Prior to enrolling in the PhD program in Counseling Psychology, Claudine Anderson was the Director of the Counseling and Psychological Services Centre, Northern Caribbean University, Jamaica. She has presented at a number of conferences and is attending the APA Convention for the first time.

A thank you to Carl Auerbach, Georgi Antar, and Vincenzo Teran, who served as the selection subcommittee of the International Committee to determine the recipient.

To disseminate information about the work of international trauma psychologists, particularly those residing in or having resided in other parts of the world was the impetus for the special section of the Spring Trauma Psychology Newsletter edited by Elizabeth Carll, PhD. If you are a trauma psychologist residing outside of the U.S. and are interested in submitting an article for the newsletter, please contact Dr. Carll, international section editor, at ecarll@optonline.net.



Elizabeth Carll, PhD

International Psychologists

Division 56 is seeking international psychologists to write articles for upcoming editions of the *Trauma Psychology Newsletter*. Please contact Elizabeth Carll at ecarll@optonline.net for more information or to submit an article.

Reflections on Ebola Crisis Communication: An Opportunity for Traumatic Stress Professionals

By Dana Rose Garfin, PhD, Lise Elin Stene, MD, PhD,
Rafael Kichic, and Clarissa Belle

As professionals in the field of traumatic stress research, we are too aware of the short and long-term suffering that trauma exposure causes individuals, families, and societies. Large-scale negative events such as terrorist attacks, mass shootings, and pandemics directly expose millions of people to trauma, and may result in acute and posttraumatic stress responses in addition to other deleterious outcomes. Moreover, emerging research in the field of traumatic stress has demonstrated that even people who are not geographically proximal to a community disaster may still experience acute and posttraumatic stress symptoms typically associated with direct exposure to an event (Holman, Garfin, & Silver, 2014; Schlenger et al., 2002; Silver, Holman, Poulin, McIntosh, & Gil-Rivas, 2002). News coverage of a community disaster is accessible 24/7 via television, radio, Internet, Smartphones, and tablets, creating a shared experience that can generate critical empathy for the suffering of others, yet simultaneously elicit stress responses in individuals far from the actual event (Holman et al., 2014).

The 2014 outbreak of Ebola in West Africa is one example of a community crisis that exposed many geographically distal individuals to disturbing information, posing a unique set of challenges for clinicians and public health, media, and policy professionals. Combatting and containing the virus was, and continues to be, of critical importance to aid people in West Africa and around the globe. Yet, accomplishing this task effectively, responsibly, and without spreading traumatic stress responses throughout the population poses a number of difficulties. As of the end of November, 15,152 people had contracted Ebola and 5,420 died as a result of the virus (Center for Disease Control [CDC], 2014). Fortunately, the direct impact of Ebola in

the United States was significantly less; 4 Americans were infected and one died (CDC, 2014). Despite these facts, data from polls and search engines indicated that Americans were quite concerned with the crisis – and not only as it impacted people in West Africa. Indeed, many worried about Ebola as a threat to personal health

in the United States. According to a poll from the Harvard School of Public Health, 73% of Americans ranked the danger of Ebola as extremely or very important, 39% were concerned about a potential large outbreak, and 26% were concerned they or someone close to them may be infected in the next year (Harvard School of Public Health, 2014). Overall, there appeared to be a stark incongruence between risk appraisals of contracting the Ebola virus and actual risk.

Such concerns were likely driven by the sensationalized media coverage and graphic imagery that resulted in emotional and fear-based cognitive processes of a horrific disease, rather than accurate perceptions of risk. Prior research on large-scale community disasters has demonstrated that high levels of media exposure to events may correlate with increased traumatic stress responses throughout the population (i.e. Holman, 2014; Holman et al., 2008; Ahern et al., 2002). For example, findings after the September 11th, 2001 terrorist attacks (9/11) and the Boston Marathon bombing indicated strong associations between high levels of media-based exposure to traumatic events and acute (Holman, 2014) and post-traumatic stress responses (Ahern et al., 2002), which can have long-term implications for physical health (Holman et al., 2008; Silver et al., 2013).

Since 9/11, the potential for media exposure to traumatic events has increased with the proliferation of portable technologies (e.g., Smartphones), facilitating exposure to multiple communications simultaneously. Indeed, in the aftermath of the 2013 Boston Marathon bombings, many Americans reported that they were exposed to news coverage from multiple sources simultaneously (Holman et al., 2008). For example, one could receive



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Twitter updates while watching online videos or watch television while searching for additional news online.

Graphic images, such as injured or dead bodies, were prominent in media coverage of the Ebola crisis. This graphic coverage may be particularly detrimental and may be a key factor influencing the emergence of media-driven acute and posttraumatic stress. In the wake of 9/11, people who reported a high frequency of seeing television images of people falling or jumping to their death endorsed a higher prevalence of PTSD symptoms (Ahern et al., 2002). Furthermore, recent research conducted in laboratory settings using fMRI machines suggests that viewing such traumatic imagery can elicit PTSD-like flashbacks similar to those typically expected from direct exposure to traumatic events (Bourne, Mackay, & Holmes, 2013). Traumatic images, whether in person or through media, may leave similar cognitive imprints, with a variety of implications for how to communicate information during a horrific community event.

With respect to the 2014 Ebola crisis, traumatic stress responses themselves likely posed considerable detriment to public health and diverted essential financial and human resources from locations most directly impacted by the virus. Yet, communicating with the public about the dangers of Ebola and other health crisis while eliciting sympathy and concern in order to help those most in need is imperative. How to balance these somewhat conflicting goals must be a discussion for those in the field of traumatic stress, public health policy, media reporting, and service provision. Clinicians, researchers, and other professionals in the field of traumatic stress may play an essential role in helping journalists and policy makers decide on the best way to convey important information without inadvertently generating traumatic stress responses. At the individual level, clinicians should be aware that their clients' anxiety or other psychopathology may be exacerbated by these external social phenomenon.

Media can be a crucial bridge between health authorities and the public. Proper media coverage of an epidemic can be an invaluable resource to communicate effective prevention measures, contribute to the identification of infected individuals, and reduce morbidity and mortality. Apocalyptic views about Ebola are likely to fuel un-

necessary threatening interpretations about minor physical symptoms, with adverse consequences for health care facilities and service providers. Such ramifications occurred in the midst of the 2009 outbreak of influenza H1N1. H1N1 was extensively covered in the media, although the threat to health in industrialized nations was later judged as overrated (Trivellin, Gandini, & Nespoli, 2011). This resulted in a substantial increase in emergency department visits even in a period with absence of actual H1N1 influenza in the community (McDonnell, Nelson, & Schunk, 2012). This sudden surge in consultations can adversely impact the delivery of health care due to treatment delays, lower quality of care, and higher risk of medical errors. Subsequent years indicated a lower adherence rate to influenza vaccination campaigns, perhaps due to diminished trust in public health recommendations, potentially counteracting prevention of future disease outbreaks (Trivellin, et al., 2011).

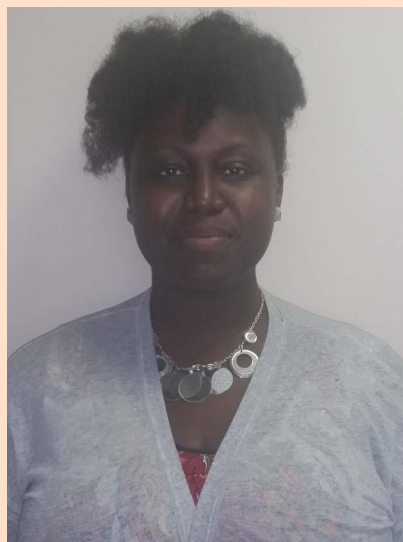
People's fear of being infected during visits to health clinics can also prevent people from seeking health care. For example, the severe acute respiratory syndrome (SARS) epidemic in 2003 correlated with a substantial decrease in health care utilization in areas most affected by the epidemic (Chang et al., 2004). Moreover, as seen in the midst of the Ebola crisis, exaggerated fear of transmission may incite stigmatization of persons infected or believed to be at risk, hampering identification, treatment, and quarantine efforts. The mandatory quarantines initially proposed by the CDC sought to mitigate public fears of the disease; however, this extreme policy was, ironically, later criticized for jeopardizing long-term disease control efforts (Chang et al., 2004).

It is vitally important for government officials and experts in the field of traumatic stress and public health to be profound and active voices steering conversations related to Ebola. However, such voices must be cognizant of the manner in which information

is relayed to the general public, as this communication greatly influence individual's ability to make realistic and plausible estimates of risk (Glik, 2007). This is particularly relevant when communicating about a deadly disease like Ebola; prior research has consistently indicated that presenting uncertainties accurately to the public may increase accurate risk perceptions (Johnson & Slovic, 1995). This is in contrast to many news reports



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that may have focused on “worst-case scenarios.” Indeed, it was difficult for people to discern *who* in America was exposed and *when*, resulting in mandatory quarantines for individuals returning from Ebola-afflicted countries in West Africa. Individuals are likely to rely on heuristics (i.e., cognitive processing strategies that help generate conclusions quickly and efficiently) as they attempt to understand and process information about the Ebola epidemic (Glik, 2007). These heuristics may bias probability estimates: when individuals read about the threat of Ebola globally, it may cause them to feel that “all of us” are at an increased risk of contracting Ebola, instead of primarily those in West Africa.

When people are provided with appropriate communications regarding a public health emergency, perceptions of risk tend to have higher validity (Glik, 2007), providing an opportunity to reduce event-related traumatic stress. Rates of serious infectious disease will likely increase in the coming years due to factors such as climate change and overpopulation. Given this, it is critical for professionals in the fields of public health and traumatic stress to promote media communications that inform the public about health risks in an effective, appropriate, and accurate manner that does not sensationalize events, potentially resulting in adverse outcomes for the physical and mental health of the populace. Such promotion efforts may include working with the media to accurately communicate risks to the public or encouraging people to stay informed yet refrain from repeated exposure to potentially disturbing images which may elicit PTS reactions and information that many inaccurately bias risk perceptions. In sum, alongside serving the clinical needs of a distressed population, traumatic stress professionals should seek to play an integral role in guiding policy makers and media sources towards the responsible and accurate response to important public health threats.

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Recovery

By Jodi D. Bremer-Landau, PhD

Hemingway (1957) said “The world breaks everyone and afterward many are strong at the broken places” (p. 318). These words held personal significance when a serious accident changed my life forever. Not only was I in and out of consciousness for days, but upon waking I learned that I had a traumatic brain injury (TBI) that would prevent my immediate return to school. From that moment, I was faced with not only a physical recovery, but an emotional one as well. What would recovery look like? Would I be able to successfully return to my second year of a rigorous doctoral program and fulfill my dream of becoming a psychologist? Despite these fears and a painful rehabilitation, I reached out to professionals who helped me learn the following elements of the recovery process: connectedness, hope and optimism, identity, meaning and purpose, and empowerment (CHIME; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Using these skills in addition to perseverance and support, I succeeded in my rehabilitation, and returned to my studies after making a full recovery; I truly became “strong at the broken places.” Through recovery and personal growth, my TBI no longer symbolized disability and loss, but a badge of honor marked by courage and resilience. My experience solidified my desire to help others find their inner strength, so that they can transverse mental, physical, and life adversities.

Given my personal experiences and professional interests in trauma, I became eager to understand more about the concept of recovery-oriented mental health care. I learned that recovery is not a new concept; in fact, I discovered there had been a shift in the way that recovery has been viewed over the past few decades. Beginning in the 1970s and 1980s, recovery models began to have less emphasis on mental health issues as a permanent impediment to achieving goals, and began focusing on an individual’s ability to make progress towards living a values congruent life despite mental health symptoms (Roberts & Boardman, 2013). The following definition encapsulates an often accepted meaning of mental health recovery (Bird et al., 2014).

Recovery is described as a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the

development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993, p. 527).

From a personal perspective, I could certainly relate to the aforementioned definition. My world changed in an instant and it took a while to re-learn much of what I took for granted, such as walking steadily, interpreting social cues, or understanding abstract concepts written in books. I often found myself pensive with existential questions, and I naturally began to explore my values, goals, and attitude about life. Feeling *connected*, holding desperately on to *hope*, integrating my experiences with my *identity*, finding *meaning*, and feeling *empowered* despite losing some independence in early recovery were the CHIME processes essential to my recovery. Furthermore, they are what helped me to persevere despite lacking direction and being utterly both emotionally and physically exhausted. For instance, I had been emotionally numb for a period of time and when my emotions returned, they were negative and fierce, with anger often taking the lead. Despite a lack of understanding for the reasons behind

the emotional numbness and subsequent negative emotions at the time, my *connection* with others and their encouragement instilled a great sense of *hope* that my current state would be temporary and that I would be able to experience positive emotions in the future. At times during my recovery, I also felt *empowered* and *optimistic* about the future because of the support in my life, as well as with the small incremental changes I began to notice. As a result, I continued to traverse through the negative emotional landscape until I gradually began to feel positive emotions.

After returning to school, my personal recovery influenced my professional practice. I grew stronger as a clinician and developed deeper connections with my clients with my increased empathy and understanding. Recovery-based care soon became an underlying philosophy in my clinical work. I found that utilizing the CHIME processes (Leamy et al., 2011) as a framework for measuring change in conjunction with evidence-based interventions enabled clients to find social *connectedness*, increase *hope*, explore *identity*, develop deeper *meaning*, and feel *empowered* to achieve their therapeutic goals and find their place of strength.

Providing recovery-oriented services was especially helpful for working with individuals navigating trauma-



Jodi D. Bremer-Landau, PhD

related mental health issues, such as with those that developed posttraumatic stress disorder (PTSD), a specialty area in which I have always had an avid interest. As one might expect, TBI and PTSD overlap in symptomatology, such as with emotional numbing, depersonalization, and derealization (Bryant, 2011). These similarities served to expand upon my personal and professional knowledge base of the effects of different types of trauma and the importance of providing recovery-oriented care.

While “recovery” is not considered an intervention (Farkas, 2007), CHIME can be used as a framework to assess change (Leamy et al., 2011) and inform treatment. For example, I have borrowed positive psychology concepts to underscore an individual’s strengths (Resnick & Rosenheck, 2006) and their ability to persevere despite challenges in order to help *empower them when confronting trauma-related issues. By focusing on empowerment, individuals were able to make therapeutic progress, such as when working through avoidance. Similarly, cognitive processing therapy has helped individuals explore, challenge, and adapt thoughts, feelings, and beliefs (Monson et al., 2006) to find new meaning and purpose in their lives. In this regard, finding new meaning and purpose seemed to be instrumental for therapeutic change. Speaking with individuals in therapy about the research on trauma-related intervention effectiveness has served to inform as well as instill hope and encouragement. Furthermore, I have found that helping individuals connect and receive personal and professional support from others has been instrumental with their recovery from trauma.*

Providing recovery-oriented services can be advantageous for individuals’ recovery and future research aimed at providing implications for practice is essential. Research on developing a better understanding of recovery, recovery processes, and ways to effectively measure recovery would be beneficial (Leamy et al., 2011). Cultural implications of recovery is another area that could be addressed further. In particular, CHIME may be applicable cross culturally (e.g., United Kingdom, Australia) but additional research on the generalizability of CHIME processes is needed (Slade et al., 2012). Furthermore, understanding socioeconomic status in rela-

tion income level and access (or lack thereof) to recovery-oriented services may also prove beneficial (Slade et al., 2014).

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Jodi Bremer-Landau recently earned her Ph.D. in counseling psychology from Lehigh University after completing an APA-accredited internship at Battle Creek VA Medical Center. She has since launched a private practice in Quakertown, Pennsylvania, where she specializes in trauma, PTSD, substance abuse, and sleep-related concerns.

Call for Fellowship Applications

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

APA members who are not yet Fellows of any APA division must meet APA Fellow criteria, apply for Fellow Status according to APA procedures, and complete the APA forms, all described at <http://www.apa.org/member-ship/Fellows/index.aspx>. You will find everything you need to know about applying at the above APA web address.

In addition to meeting the APA criteria, applicants must meet Division 56 criteria, listed below.

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

1. Being a pioneer in the recognition and application of trauma psychology
2. Publishing important publications to the field of trauma psychology
3. Producing consistently outstanding instructional or training programs that educate the next generation of trauma psychologists or developing important innovations in teaching or education in the field.
4. Demonstrating consistently outstanding clinical work with the traumatized as recognized by international or national groups through citations,

awards, and other methods of recognition.

5. Demonstrating consistently outstanding public service relevant to trauma psychology over many years that might include (a) leadership within Division 56; (b) testimony about trauma psychology before courts and Congressional committees or government commissions; (c) service on review panels (e.g., NIH, NSF); or (d) public education/advocacy.
6. Demonstrating leadership in the area of trauma psychology across science, education, policy, and practice internationally and/or nationally.

In order to meet APA’s February 2016 deadline, Division 56 requires that all new Fellow application materials (including recommendations) be submitted through the APA web site by **November 1**. This timeframe will allow our Fellow committee to review all materials, make a recommendation, and forward completed application materials to APA in time to meet their deadline.

If you are a current Fellow in another APA division, we ask for a letter describing the ways your work meets the above Division 56 Fellow criteria. We also ask for three letters of recommendation from current Fellows, at least one of which must come from a Division 56 Fellow (listed on our web site at <http://www.apatraumadivision.org/honors.php>). Please submit these materials by e-mail to Laurie Pearlman (lpearlmanphd@comcast.net). We accept these applications on a rolling basis throughout the year. They do not go through the APA web-based application process.

We welcome all who are interested and qualified to apply! If you know a Division 56 member whose work meets these criteria, please encourage that person to apply.

Division Fellows List Update

The list of Division 56 Fellows on our website is being updated. If you believe you are a Fellow in our division and you do not see your name there, please contact Laurie Pearlman, Division 56 Fellows Committee Chair (lpearlmanphd@comcast.net).

Review of *Treating Traumatic Bereavement: A Practitioner's Guide*

Pearlman, L. A. Wortman, C. B. Feuer, C. A., Farber, C.H., and Rando, T. A. (2014) *Treating Traumatic Bereavement: A Practitioner's Guide*. New York, NY: Guilford Press (358 pages) ISBN-13: 978-1462513178 ISBN-10: 1462513174 (\$45.00 paperback).

By Lisa Y. Livshin, EdD

Treating Traumatic Bereavement is a comprehensive book (358 pages) on traumatic bereavement, which is defined by the authors as being the result of “a sudden, traumatic death, which is abrupt and occurs without warning.” Other aspects of traumatic death are those that are untimely, involve violence or mutilation, or are perceived by the survivor as having been preventable. Sometimes the survivor experiences many losses at once or the survivor’s own life was threatened. Inherent in this book is the recognition that the trauma must be processed in order to allow the survivor to fully attend to mourning and adapt to the loss. As a clinician who specializes in traumatic grief and disaster mental health, it is exciting to read a book which fully explores the impact of trauma on loss and grief. The authors present various theoretical foundations (Cognitive-behavioral, Relational, Constructivist Self Developmental) which inform their treatment approach. Through these frameworks, they explore how loss and psychological trauma are defined, and how they are processed by the client.

Treating Traumatic Bereavement: A Practitioner's Guide also contains a treatment manual. After laying the foundation for a model to treat traumatic bereavement in the first half of the book, the authors focus on the implementation of the techniques and concepts. They have constructed a 25 session plan for working through both the trauma and loss. Parts of it can be used as needed, however, beginning clinicians or those new to this field may prefer to adhere to the treatment plan. Purchasing the book allows the practitioner access to a companion website containing the session planner and over 30 handouts, several of which I have used in my practice. For instance, a recent suicide survivor found the supplemental handout on “Getting through the Holidays” very helpful. I valued being able to give the client something to take away with her over the difficult Thanksgiving holiday. The worksheet on secondary

losses following the traumatic loss of a loved one, was well written and helped several of my patients identify and put words to their experiences.

There are “three core components” to the treatment plan:

1. The authors stress the importance of developing internal and external resources to support the processing of the trauma and to facilitate the mourning process. Chapter 10, *Building Resources* (and its accompanying handouts) provides excellent guidance for assisting the patient in building internal stability (self-capacities, coping skills, breathing retraining) and an external support system. What clinician couldn't use ideas about how to help clients develop these resources? While of course this chapter was geared to traumatic bereavement, there is much value in using these ideas and techniques with other clinical populations.

2. The authors stress that the traumatically bereaved individual must process the loss both cognitively and emotionally. The rationale for this second core component is based in Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), and Constructivist Self Developmental Therapy (CSDT). The accompanying handouts are helpful, particularly Handouts 10 through 14, which constitute a CBT primer on identifying and challenging automatic thoughts.

3. The third core component is “moving through the processes of mourning,” which are Therese Rando's (Rando, 1993) tried and true, 6 “R” Processes of Mourning: Recognize the loss, React to the separation, Recollect and Reexperience the deceased and the relationship, Relinquish the old attachments to the deceased and the old assumptive world, Readjust to move adaptively into the new world without forgetting the old, and Reinvest. If you are not familiar with these, I recommend becoming familiar with them. I have taught the “6 R's” in my graduate school classes for many years and use them to guide my treatment with grieving patients.

However, this book does not take a cookie cutter approach to traumatic grief. Part III of the book (*Risk Factors And Related Evidence*) is devoted to understanding potential factors affecting how one



Lisa Y. Livshin, EdD

processes the trauma and the loss. These include: event-related factors (characteristics and mode of the death), and person-related factors (gender, personality and coping strategies, spiritual/religious beliefs, nature of relationship with the deceased, attachment style). These factors are thoroughly discussed and supported with recent research in the field. Each chapter begins with a clinical vignette illustrating the challenges of developing an appropriate treatment approach. These were helpful in setting up the chapter's focus and I think they would be especially valuable to beginning trauma therapists.

Finally, the concluding chapters, which cover working with challenging clients, self-care and vicarious traumatization for therapists, are valuable resources during treatment implementation. I highly recommend this book and will add it to my required reading list for

graduate students studying traumatic bereavement. I plan to refer to this book and its accompanying handouts regularly in my private practice.

***Lisa Y. Livshin, EdD**, is a licensed psychologist in private practice in Massachusetts where she specializes in the evaluation and treatment of trauma. She is the Boston Team Liaison for the Massachusetts Disaster Response Network. Dr. Livshin also serves as a crisis consultant and in that capacity, has worked most recently with survivors of the Boston Marathon Bombings. She is an Adjunct Professor in the Division of Counseling and Psychology at the Lesley University Graduate School of Arts and Sciences where she teaches Disaster Mental Health. Since 1987, she has been a Clinical Instructor in Psychiatry at Tufts University School of Medicine.*

Division 56 Member Services

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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

Listserves: Everyone is added to the announce listserv, div56announce@lists.apa.org (where news and announcements are sent out; membership in Division 56 is required).

To join the discussion listserv, div56@lists.apa.org (where discussion happens; membership is not required), send a note to listserv@lists.apa.org and type the following in the body of the note: subscribe div56

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

Newsletter: The newsletter is sent out on the division listservs and is available on the website at www.apatraumadivision.org/newsletter.php

Membership Issues: Email division@apa.org or phone 202-336-6013.

Who's Who: Bryan T. Reuther, PsyD

Bryan T. Reuther, PsyD, is an Assistant Professor of Human Services at Indian River State College in Fort Pierce, FL. His research interests include theoretical and philosophical psychology, existential psychology, and trauma. Prior to his academic post he was the Postdoctoral Resident at Nova Southeastern University's Adult Services Outpatient Clinic. He has published in the *Journal of Theoretical and Philosophical Psychology*, *Encyclopedia of Trauma* (Ed. Charles Figley; Sage, 2013), and *Encyclopedia of Critical Psychology* (Ed. T. Teo; Springer, 2014). Additionally, he is currently working on a PhD in Philosophy at the University of Essex, UK.

What is your current occupation?

I am currently an assistant professor of Human Services at Indian River State College located in Fort Pierce, Florida, where my main responsibility is teaching in the BS program for Human Services. Some of the courses I teach included Trauma and PTSD, Existential and Humanistic Counseling Theory, Crisis Intervention, and Cognitive-Behavioral Theory. My research centers on theoretical and philosophical psychology, existential psychology, and trauma. In addition, I am also a research affiliate with the Trauma Resolution and Integration Program at Nova Southeastern University.

Where were you educated?

I received my BA in Psychology and Criminal Justice (Double Major) from the University of Central Florida. I completed my MS and PsyD in Clinical Psychology from Nova Southeastern University, where I specialized in trauma psychology. I completed my pre-doctoral internship at Henderson Behavioral Health Crisis Stabilization Unit, which is part of the South Florida Internship Consortium Program at Nova Southeastern University. After graduating, I did my postdoctoral training in general clinical psychology at the Adult Services Outpatient Clinic at Nova Southeastern University. Currently, I am working on a PhD in Philosophy at the University of Essex, located in Cochester, UK.

Why did you choose this field?

This is a tough question for me to answer in a straight-

forward way. I imagine many people may have an inspiring story or experience that made it clear to them that clinical psychology, and perhaps more specifically, trauma psychology, was their calling. For me, it was a confluence of several experiences, alongside opportunities that led me to this field. I actually come from a long line of public service workers, particularly law enforcement,

so my initial plan was to work within the criminal justice field. After doing some work in crime analysis/mapping and environmental criminology (sociology) as an undergraduate, I became more interested in examining the psychological factors that led to not only criminal behavior, but also human behavior in general. Meanwhile, I was also completing an internship in Victim Services at UCF, which opened my eyes to the field of trauma psychology in the context of the justice system. While initially planning to study forensic psychology in graduate school, I joined Steve Gold's research team at the end of my first year as a result of a recommendation from a fellow student, which proved to be quite formative in my education. After learning and training in Gold's contextual model, alongside my rapidly developing interest in existentialism, I had pretty much

settled in terms of choosing to focus my studies and clinical work on trauma.

What is most rewarding about this work for you?

As a clinician, it is the opportunity to help a person overcome the many challenges that accompanies trauma. This goes beyond symptom reduction and skills training to bearing witness to a person living a more authentic and meaningful life on his or her own terms. For me, it's about helping the person not only (re)gain agency, autonomy, and identity but also feel fundamentally connected in his or her world. As a professor, it is all about students learning and achieving their educational and career goals. Many of the courses I teach have an applied, clinically-oriented component, where students are required to facilitate mock therapy sessions. Here, I greatly enjoy watching my students demonstrate certain skills and therapeutic styles effectively as well as hearing the constructive feedback they provide for their peers. It really shows me they are grasping the essence of counseling and clinical work, and that I am doing my job.



Bryan T. Reuther, PsyD

What is most frustrating about your work?

Simply put: Reductionistic thinking. What I mean is thinking that attempts to reduce trauma to either a neurobiological process, treated with medication alone, or to mere symptoms that need to be addressed in a technician-like way. While interventions and medications surely do have their place, we cannot forget the suffering human being in our work.

How do you keep your life in balance?

I really make sure I take time to relax and engage in pleasurable activities. Exercising is extremely important to me, and most days of the week I can be found running or weight training. Reading philosophy is always invigorating for me, and I find that I can recharge myself though studying philosophy—it has really developed into

quite the hobby! In addition, I enjoy spending time with family and friends, especially my girlfriend and dog. Beyond the aforementioned, what really guides my life is the following: I really find it interesting that most things do not happen according to plan, life is unpredictable and messy, and sometimes down-right terrible. However, I think that if we wait a moment, embrace the uncertainty, step back, and allow the larger story to unfold, the events that transpire—and life in general—may begin to make a whole lot more sense.

What are your future plans?

I plan on gaining tenure in my current faculty position, starting a small private practice specializing in trauma, and finishing my PhD in philosophy all within the next five years. Moreover, I'd like to continue my service to Division 56 in whatever capacity I am most needed.

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Join us for Division 56 activities.
See pages 5-7 for more information and
see our full program on our website.

Division 56 Member News

Kathy Kendall-Tackett, Ph.D. & Lesia Ruglass, Ph.D. have a new introductory trauma textbook called *Psychology of Trauma 101*, published by Springer Publishing. Review copies are available.

Kathy Kendall-Tackett, Ph.D. also completed three international trips teaching on trauma and perinatal mental health. In London, she worked with a group called Best Beginnings. They are targeting young, low-income, pregnant women with a highly successful app that is helping to decrease high infant mortality rates in this population. The app helps these young mothers monitor their health, quit smoking, exercise, take their folic acid and prenatal vitamins, and attach to their babies. It also has lots of short video clips showing mothers interacting with their babies in positive ways. Many of these young women have trauma histories and want to learn to parent differently than they were parented. Best Beginnings is now also adding a component on perinatal depression. She served as a script consultant to the film they are producing, trained their staff and other stakeholders, and taped a series of clips to be included in the app.

In Leicester, she spoke at the Lactation of Great Britain conference, where she talked about mother-infant sleep, depression, trauma, and ethnic disparities. She also described the role of trauma in high-BMI.

In Denmark, she presented a day-long conference on perinatal depression, causes and treatments. The talk highlighted the role of trauma in perinatal depression and how trauma primes the inflammatory response system, making trauma survivors more vulnerable to stress, drawing from the literature on psychoneuroimmunology.

In China, she worked for week at a maternity hospital, training staff and talking to parents about perinatal depression. The CEO of the hospital said he now realizes that they need to address mothers' mental health and they are going to start a program for their mothers that addresses mental health concerns, such as postpartum depression, PTSD, and anxiety disorders.



Kathy Kendall-Tackett, PhD



Lesia Ruglass, PhD

Michelle Barrett, MA, is a Psy.D. student at Antioch University Santa Barbara. Next month, she will be defending her dissertation which relates to secondary traumatic stress. The title is: *The relationship between empathy and humor styles and secondary traumatic stress in the public mental health workplace*. The purpose of this study was to determine if there is a relationship between both empathy type and humor type to secondary traumatic stress in individuals who work in a public mental healthcare setting. Empathy type was divided into four subcategories: Perspective Taking, Fantasy-type, Empathic Concern, and Personal Distress. Similarly, humor type was divided into four subcategories: Affiliative, Self-Enhancing, Aggressive, and Self-Defeating. Clinical and non-clinical staff at the Alcohol, Drug, and Mental Health Services department of Santa Barbara County, California participated in an online survey. The survey consisted of a sociodemographic questionnaire, as well as questionnaires related to humor, empathy, and secondary traumatic stress. Non-clinical staff was more likely to endorse STS and to report significantly higher scores Personal Distress Empathy scale, in comparison to clinical staff. Further, a significant relationship was found in both clinical and non-clinical workers to Perspective Taking and Fantasy-type Empathy. Finally, both clinical and non-clinical staff who endorsed significantly higher STS were also more likely endorse higher scores on Self-Defeating and Self-Enhancing Humor scales. Results showed that non-clinicians were more likely to report psychological distress than their clinical counterparts. Further, humor related to oneself was likely to be indicative of STS, as were the cognitive empathy types.

Elaine Ducharme Ph.D, ABPP, recently published a new book titled *Assessment and Treatment of Dissociative Identity Disorder*. It is published by TPI Press and is available through them, on Amazon or through Dr. Ducharme directly at elaine.ducharme@yahoo.com.

Dr. Kathleen carterMartinez is an author, educator and clinical psychotherapist. For years she has been

a tireless advocate and voice for women affected by physical and emotional trauma. From the foundation of her education and expertise as a clinician she uses her gift as a storyteller to weave a tapestry of empathy, compassion and understanding for those who know what it means to try to live their life in the shadow of physical and emotional trauma that are the result of rape and sexual assault.

Using her gift as a storyteller she gives a voice to women everywhere who have a story to tell. 'Dr. Kc' words resonate as she reminds people that trauma affects each and every one of us. 'Dr. Kc' compels individuals to remember that we are all members of the human condition as she calls readers to sit together in the circle of life and invites them to travel the journey to healing together. Her new book on this topic is titled: *Permission Granted: The Journey from Trauma to Healing from Rape, Sexual Assault and Emotional Abuse* which will be released by CheyWind Press by September 1, 2015.

Last spring the Journal of Family Violence published an article by **Sarah Krakauer, Psy.D.** in an issue focusing on research on attachment styles in relation to trauma and abuse. In this article she presents a case demonstrating the potential for developing internal working models of attachment in the absence of adequate attachment history. The distinguishing feature of this process was that the client – a dismissing (avoidantly-attached) client with DID abandoned in early childhood – formed her initial attachment in therapy not with the therapist, but with an unconscious inner guidance resource characterizing the Collective Heart model (Krakauer, 2001). This treatment model targets posttraumatic misattributions of power and quickly challenges the client's perceived brokenness and helplessness. The inner guidance resource appeared to the client as a nurturing female during autohypnotic work early in therapy, and was soon named "My Wise Mother" by the client. The article offers extensive verbatim case material illustrating the interventions that potentiated this "Wise Mother's" guidance of the client's identity development and mastery of relational tasks by mining and augmenting rudimentary fragments of attachment experience. The client's attachment to the therapist developed over a period of years - long after the client first experienced attachment to her "Wise Mother." Citation: Krakauer, S. Y. (2014). Must Internal Working Models be Internalized? A Case Illustrating an Alternative Pathway to Attachment. *Journal of Family Violence*, 29(3), 247-258.



Carlos Cuevas, PhD

Carlos Cuevas, Ph.D. & Callie Rennison, Ph.D. will be recently edited a new text called *The Wiley Handbook on the Psychology of Violence*, which will be released this December. The text presents a collection of original readings that explore all major aspects of the psychology of violence, aggression, and other criminal behaviors. Utilizing an interdisciplinary approach, readings are contributed by a diverse group of experts, including psychologists, criminologists, sociologists, and others. Coverage is included on topics that range from general issues relating to violence and victimization to emerging problems of online violence and cybercriminal behaviors. Other topics covered include aspects of juvenile violence, sexual violence, family violence, and various violence issues relating to underserved and/or understudied populations. Featuring the most current empirical evidence and theoretical findings, Handbook on the Psychology of Violence will provide

information to those with an interest in the current state of violence research, practice, and policy. Citation: Cuevas, C. A., & Rennison, C. M. (Eds.). (2015). *Wiley Handbook on the Psychology of Violence*: Chichester, UK: John Wiley & Sons.

Rochelle I. Frank, Ph.D. is one of the authors of *The Transdiagnostic Road Map to Case Formulation and Treatment Planning: Practical Guidance for Clinical Decision Making*, which was released by New Harbinger last August. While the book details an overarching approach to treatment of a wide range of patient problems, it includes many specific references to and examples of individuals with trauma and dissociative disorders. It is also unique in identifying and categorizing the psychological mechanisms underlying those and other presenting problems, as well as guiding clinicians in mapping those transdiagnostic mechanisms to patient-specific treatment interventions.

Nora Baladerian, Ph.D. has a new publication titled *A Risk Reduction Workbook for Parents and Caregivers of Children and Adults with Intellectual and Developmental Disabilities*. Statistics reveal that most children with I/DD will be victims of abuse many times over during their lifetime. Parents (and others) until now have been at a loss as to how to reduce their child's risk of abuse. They have also been at a loss to know what to do when they suspect abuse as well as when abuse is discovered or disclosed. This book fills all of those gaps. The essence of the text is to provide vital information to parents/caregivers, who in turn will provide such information to their children. This is

a skills-based planning process, to exploit the existing skills of each individual child to increase awareness of the people around them (90% are abused by household, school, or other authorized caregiver), as well as develop skills that can help them avoid abuse or reduce the psychological impact of such abuse. Case examples are also provided. Taken into consideration is the fact that many children and adults have communication disabilities and until now likely did not have a way to disclose abuse, the sample communication guide within the book starts a communication method for them on this issue. The book is available in print form or PDF from the website, www.disabilityandabuse.org where reviewer's comments can be read. More information about abuse of children and adults with intellectual and developmental disabilities, including the 2012 National Survey on Abuse of People with Disabilities, can be found at their website along with additional books, DVD's and other materials.

Jim O'Neil, Ph.D. has recently published a summary of 35 years of men's gender role conflict (GRC) entitled: *Men's Gender Role Conflict: Psychological Costs, Consequences, and an Agenda for Change* (O'Neil, 2015, APA Books). The book is a call to action for more focused attention on men's lives in both the psychological

and interpersonal realms. Combining over 30 years of research in men's psychology and the author's own experience in conceptualizing GRC, this book promotes activism and challenges the status quo, calling on researchers and clinicians to confront GRC and reduce its harmful effects, which has widespread implications for working with trauma as well.



Ani Kalayjian, EdD, DDL, BCRN, BCETS, DSc (Hon)

Ani Kalayjian, EdD, DDL, BCRN, BCETS, DSc (Hon) delivered 6 lectures on the «Prevention of Genocide: Transforming Generational Trauma,» in Arizona State University Law School, in Department of Finance, and Accounting of US Government in Cleveland Ohio, in Richmond Heights Cleveland, in New York, and in Brooklyn. She organized and chaired 2 conferences at the United Nations, as part of ATOP Meaningfulworld NGO affiliated with the DPT. One parallel workshop to the CSW on Transforming Violence Against Women, and the

other on Mind-Body-Eco-Spirit Health Transforming Racism. Ani also organized, chaired and presented a panel at the Eastern Psychological Association. She organized, and spearheaded a Humanitarian Mission of Empowerment for Peace in the Middle East in May, and now planning for the Humanitarian Mission to Haiti in June.

Social Media News

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The Division of Trauma Psychology—Your Home in APA

The Division of Trauma Psychology adds a psychological voice to the interdisciplinary study of trauma, offering knowledge from science and practice with the goal of enhancing clinical care, research, and education of psychologists.

Why join Division 56?

Members: Join a community of professionals committed to scientific research, professional and public education, and the exchange of collegial support for professional activities related to psychological trauma.

Early Career Psychologist Members (ECP's): Gain access to extensive networking opportunities with colleagues in the trauma field. Other benefits include professional development training, social hours and mentoring sessions at our annual conferences, and opportunities to write for the Division 56 newsletter.

Student Members: Become part of a nationwide network of fellow students with professional interests in psychological trauma. Benefits include opportunities for networking with experts in the field and access to the Division 56 Student Listserv, a forum in which students can participate in academic conversations and events regarding cutting-edge work in trauma psychology.

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- Participation in the Division's annual meetings and voting privileges to elect representatives
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- Subscription to our journal, *Psychological Trauma: Theory, Research, Practice, and Policy*, at the member rate of \$22.50 per year

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TRAUMA PSYCHOLOGY NEWS

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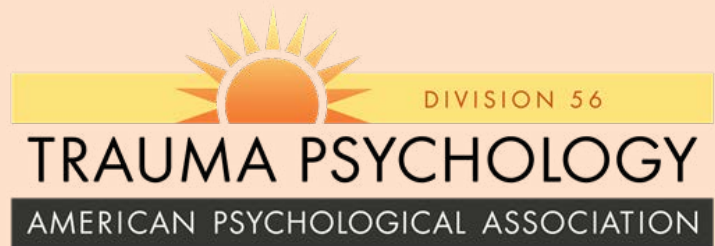
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