



DIVISION 56

# TRAUMA PSYCHOLOGY

## AMERICAN PSYCHOLOGICAL ASSOCIATION

### NEWS

#### Editor's Note

Editor's Note.....3

#### Convention

Photos from Convention Social  
Hour and Awards.....4

#### APA Takes the Hill

Trauma Psychology Takes to the  
Hill: APA Division 56 Joins APA  
Partners in Cosponsoring Policy  
Workshop & Advocacy Day .....6

#### Editorial

It's Not All Black or White:  
Response to Shedler's Psychology  
Today Blog "Selling Bad Therapy  
to Trauma Victims" ..... 10

#### Featured Articles

Intensive Outpatient Prolonged  
Exposure for PTSD in Post-9/11  
Veterans and Service-Members:  
Program Structure and Preliminary  
Outcomes of the Emory Healthcare  
Veterans Program ..... 14  
A Brief Review of the Conservation  
of Resources Theory as It Applies  
to Military Trauma ..... 18

#### International Section

Interview with Leonidas Castro-  
Camacho, PhD, ABPP ..... 21  
Refugee Mental Health Resource  
Network Database Update: An APA  
Interdivisional Project..... 23

#### Multicultural & Diversity Section

Using a Multicultural Framework  
in Trauma Psychology: Highlight  
of Division Resources ..... 24

#### Student Spotlight

WEIRD Trauma Research: We  
Can Do Better ..... 28

#### New Fellow

New Fellow: Gina McGlinchey .... 31

#### Who's Who

Who's Who: Robyn Gobin, PhD.. 32

#### Member News

Division 56 Member News..... 33

### PRESIDENTIAL VOICE

## Helping to Alleviate Trauma Around the World

By Elizabeth Carll, PhD

Coping with traumatic events have been at the forefront, both globally and nationally, resulting in much needed work by those trained to help in such dire situations. Globally, in August and September more than 650,000 Rohingya fled Myanmar due to ethnic persecution resulting in killing of families, rape, and burning of villages. The Rohingya still continue to flee their dangerous environment. It is unfathomable to think about so many people fleeing their country in such a short period of time. An imploding economy has driven almost half-a-million Venezuelans to live in Colombia. Gangs and violence resulting in families fleeing Central America are also examples of the trauma of forced migration.

Within the U.S., we have had our share of disasters and crises this year, with hurricanes, floods, wild

fires, and shootings. In October, a gunman opened fire on a crowd of concert goers in Las Vegas killing 58 people and injuring more than 500 people and was described as the worst mass shooting in U.S. history.



Elizabeth Carll, PhD

Given these tragic global and national events, the need for psychologists trained to work with trauma can be expected to increase and there is much work that can be undertaken by our members to help alleviate the pain and suffering and the long lasting effects of such incidents. Trauma psychologists are in a unique position to help deal with these increasing events and can be expected to be called upon increasingly in the future.

For example, the consequences of forced migration gave rise to my proposing the development of the Refugee Mental Health Resource Network, a project funded by

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**Complex Trauma Task Force**

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CODAPAR to create a database of volunteers to begin to deal with the consequences of these events. See article in another section of this newsletter. The Division is also fortunate to have received another CODAPAR grant proposed by Bryann DeBeer and Diane Castillo for 2018 addressing diversity issues and training, which in the long run can contribute to the reduction of xenophobia and prejudice and ultimately reduce conflict.

Trainings and publications are key to informing the public and professionals about trauma. Division 56 has been at the forefront of developing webinars for training in a variety of areas related to trauma and offering APA CE credit has been a great benefit. We are now in the process of applying for CE credits for Home Study which are on demand webinars. This is a laborious and slow process which has been spearheaded by George Rhoades and only a few of the Divisions have Home Study CE currently in place. Once finalized, this will enable those taking a webinar from the many in our archives to receive APA CE credit. George is also completing the current renewal application for APA CE for our live webinars and training.

Our Division has received excellent feedback about our publications, including our Newsletter, *Trauma Psychology News*, edited by Bryan Reuther and Tyson Bailey who edits our website. The *Division Journal* continues to grow under the leadership of Kathy Kendall Tackett.

This year three Division 56 monograph books were completed under the watchful eyes of the co-chairs of the Monograph Series, Anne DePrince and Ann Chu. APA Books has released *Understanding Elder Abuse*:

*A Clinician's Guide* by Shelly L. Jackson in October. *Creating Healing School Communities* (Santiago, Raviv & Jaycox) and *Microaggressions and Traumatic Stress* (Nadal) will be available in January. Check them out.

Also be sure to take a look at the photos from the convention and our lively and successful social hour and awards ceremony at which there was standing room only with people flowing out into the corridor. Many thanks to the Awards chair, Kathy Kendall Tackett, Program and Hospitality chairs Jessica Punzo and Robyn Gobin, and Membership co-chairs Ilene Serlin and Lesia Ruglass, and secretary Amber Douglas, whose roles all contributed to the success of the convention activities, along with our program participants.

It truly takes a village and the above are only highlights of the many activities taking place. We have been encouraging the participation of early career psychologists (ECPs) as leaders in the village and have 14 ECPs serving on the Division 56 Council, which includes elected members and committee chairs. Our dedicated chairs and executive committee are the backbone of our success and many thanks to their efforts. The Division will be in good hands with our incoming president Diane Castillo and president-elect Sylvia Marotta. We thank Joan Cook for her dedicated service to the Division as she rotates off as past president.

The Division is always in need of new volunteers and talent and we encourage you to become active, join a committee or project, and run for office, so we can continue to be a vibrant Division. We look forward to your participation.

## Editor's Note



*Bryan T. Reuther, PsyD*  
*Editor-in-Chief*

Welcome to the Winter Issue of *Trauma Psychology News*! I would like to start with a warm, personal thanks to Dr. Elizabeth Carll for her tireless efforts as our division president. Although she will be shifting to the role of immediate past president, her presidential work in international trauma psychology along with the Refugee Mental Health Network remains a major focus of our division, and a lasting part of her legacy as president. A huge welcome to Dr. Diane Castillo as our new president and Dr. Sylvia Marotta-Walters as our president-elect.

This issue is an exciting one, packed with superb content from our hard-working and brilliant members, including experiences on Capitol Hill, papers on military trauma theory and practice as well as diversity and multicultural issues in trauma work, an international committee interview, and much more. Also, please check out the pictures from our award ceremony at the APA convention in August—these memories will be sure to warm us all during these cold months!

All the Best,

Bryan



## Photos from Convention Social Hour and Awards



President's symposium on Successful Strategies for Intervening with Refugees in the U.S. and Worldwide [left to right: E. Carll, B. Khoury, E. LeVine, G. Rhoades, B. Gard, L. Castro-Camacho].



Dr. Ken Miller, Senior Psychosocial Advisor for War Child Holland, gives Invited Address on Global Refugee Crisis and Mental Health Needs of Civilians Displaced by Armed Conflict.



Tyson Bailey receives Outstanding Contributions to Practice Award.



Executive Committee members at the Division 56 reception.



Gail Wyatt receives Lifetime Achievement Award & Kathy Kendall Tackett, Awards Committee Chair at Division 56 Social Hour.



Division 56 presidents at reception celebrating the 10th anniversary of the Division becoming an official APA Division in 2007. Previous year was the 10th anniversary of the Division becoming a provisional Division in 2006.



## Photos from Convention Social Hour and Awards



Sherry Hamby receives Outstanding Contributions to Science Award.



Brian Marx Receives Outstanding Contributions to Science Award.



Sylvia Marotta-Walters receives Outstanding Service to Field Award.



Glenna Stumblingbear-Riddle receives Outstanding Contributions by an Early Career Psychologist Award.



President's Award to Kathy Kendall Tackett for Invaluable Service to the Division from president Elizabeth Carll.



President's Award to George Rhoades for Invaluable Service to the Division from president Elizabeth Carll.





*Policy Careers Panel including Diane Elmore Borbon, PhD (center)*

## Trauma Psychology Takes to The Hill: APA Division 56 Joins APA Partners in Cosponsoring Policy Workshop & Advocacy Day

*Diane Elmore Borbon, PhD, MPH, UCLA - Duke University National Center for Child Traumatic Stress*  
*Erin Hambrick, PhD, University of Missouri - Kansas City*

*Jessica Lambert, PhD, California State University, Stanislaus*

*Christopher DeCou, PhD, University of Washington*

Trauma psychologists often have the desire but lack accessible and meaningful mechanisms to engage in policy activities. On August 1-2, 2017, the APA Trauma Psychology Division (Division 56) joined APA's Public Interest and Science Government Relations Offices, APAGS, the Society for the Psychological Study of Social Issues (SPSSI-Division 9), and the Society for

Community Research and Action (SCRA-Division 27) in co-sponsoring a special summer Policy Workshop & Advocacy Day, in conjunction with the 2017 APA Annual Convention in Washington, DC. This two day event brought together nearly 70 participants from 24 states, including Division 56 members across the professional lifespan, to learn about policy and advocate on behalf of a timely legislative issue – the need for gender-responsive policies in the justice system. One specific issue of importance is the ending of the use of restraints and restrictive housing for pregnant inmates.

The first day kicked off with a warm welcome from Aaron Bishop, MSSW, Associate Executive Director of APA's Public Interest Government Relations Office followed by opening remarks from APA's President Antonio





*Policy Workshop and Advocacy Day Participants on Capitol Hill (Photo Credit - Lloyd Wolf)*

Puente, PhD. The morning session continued with two informative panels of speakers on policy-related topics. First, participants heard from APA, APAGS, SPSSI, and government agency representatives about policy fellowships for postdoctoral trainees and psychologists in Congress and the Executive Branch of government. The second panel included psychologists in policy-related careers working in local and federal government, university settings, and policy and advocacy roles. Among the speakers on this panel was Division 56 member and Policy Committee Chair Diane Elmore Borbon, PhD, MPH who discussed her 15 year career in public health and trauma policy, which has included positions in the APA Public Interest Government Relations Office, the U.S. Senate, and now as Policy Director for the UCLA-Duke University National Center for Child Traumatic Stress, which coordinates the National Child Traumatic Stress Network (NCTSN). In addition to sharing some examples from her own federal policy work, Elmore Borbon highlighted opportunities for trauma psychology students and professionals to use their scientific and clinical expertise to inform policies at the local, state, federal, and international levels. Participants were encouraged to leverage their power as professionals and constituents when advocating for change.

The afternoon session and morning session the following day shifted the focus to preparing participants to be effective advocates during their upcoming visits on Capitol Hill. APA Government Relations staff reviewed the nuts and bolts of U.S. government and effectively communicating with policymakers in Congress. Next, participants were briefed on the selected legislative issue on which the group would advocate, gender responsive policies in the justice system. APA staff briefed attendees on some important information in preparation for their meetings with policymakers, including:

- In recent decades, the number of incarcerated women in prisons or jails has increased, creating the need for gender-responsive policies in these settings.
- Most incarcerated females have committed non-violent crimes and many are still awaiting trial.
- Incarcerated pregnant women are frequently restrained or shackled during pregnancy, for example, in transport to routine prenatal visits, and labor, posing health risks to themselves and their babies.
- Restraint and shackling occurs even though pregnant inmates are at low risk for behavior problems or flight.





*Erin Hambrick, PhD, on Capitol Hill*

- There is a need for adequate training, services, safety, and supports to address the needs of women and babies in the justice system.
- APA has developed a fact sheet (<http://www.apa.org/advocacy/criminal-justice/shackling-incarcerated-women.pdf>), a consensus statement (<http://www.apa.org/advocacy/health/joint-statement.pdf>) with selected groups, and legislative language to address this issue at the federal level.

Once participants were fully briefed, they took to Capitol Hill individually and in small groups to meet with House and Senate offices from their respective states to advocate for the *Protecting the Health and Wellness of Babies and Pregnant Women in Custody Act*. This new legislative proposal that APA has been instrumental in drafting is expected to be introduced by its lead sponsors, Representatives Karen Bass (CA-37) and Katherine Clark (MA-5), later this fall. As both psychologists and constituents, the advocates conveyed information to policymakers regarding the treatment of pregnant inmates in their home states, as well as information regarding state-level gender-responsive policies (or lack thereof) to help make the case for this new federal legislation. In addition, participants highlighted three key provisions of the new legislative proposal, which would: (1) adopt federal policies to prohibit the use of restrictive housing and restraints on pregnant inmates, (2) provide a national standard of care to address pregnancy-related needs, and (3) provide state incentives to support training for staff in tactics to use in lieu of restraints and restrictive housing. For questions regarding the *Protecting the Health and Wellness of Babies and Pregnant Women in Custody Act*, please contact Amalia Corby-Edwards ([acorby-edwards@apa.org](mailto:acorby-edwards@apa.org)) or Micah Haskell-Hoehl ([mhaskell-hoehl@apa.org](mailto:mhaskell-hoehl@apa.org)) in the APA Public Interest Government Relations Office.

Among the Policy Workshop & Advocacy Day participants were many Division 56 members from across the

country, with diverse areas of trauma expertise. Below are some highlights from the experiences of several Division 56 members:

### **Erin Hambrick, PhD**

I am a Clinical Child Psychologist whose focus is child trauma. I am also an Assistant Professor in the Department of Psychology at the University of Missouri – Kansas City and the Director of Research for the Child Trauma Academy. I do not have a policy background, but have recently sought opportunities to promote trauma-focused legislation. When this workshop was advertised, I knew I needed to go and learn effective advocacy strategies and to network with my federal representatives. I was thrilled when the legislative topic was announced. My child trauma research has identified the first few months of life as a significant period of risk – moreover, adversity in these early months can have a long-term impact. As such, when making my Hill visits, I advocated for this legislation through the lens of a trauma psychologist. Amidst my nerves about being “on The Hill” and sitting in the rooms that people I admired (Senator Claire McCaskill!) worked, I used my trauma background to engage in honest and heartfelt advocacy. I spoke about the importance of early bonding experiences on development, and the risk trajectories that can ensue when such opportunities are missed. And, I found that staffers across the aisles were receptive to hearing this message. Often, I assume that legislators are “against” the initiatives that I find important simply because there is no existing legislation to address them. But perhaps one bigger issue is that legislators are not aware of the issues nor the depth of their reach. It is my job, then, to make these issues real and relevant to them. I can’t wait to go back, and I have been communicating with my representative’s state offices to keep this legislation on their radars.

### **Jessica Lambert, PhD**

I am currently an assistant professor at California State University, Stanislaus and I hold a doctorate in Counseling Psychology from the University at Albany, SUNY. My research primarily involves adults exposed to mass trauma. I am a licensed psychologist with experience treating a range of trauma-affected populations including survivors of torture, refugees, victims of interpersonal violence, and combat veterans. Since finishing graduate school nearly 10 years ago, I have had a strong interest in politics and the implications of policy for the vulnerable populations with whom I work in the US and internationally. However, I had no previous training or experience in advocating for specific legislation. When I saw the APA Policy Workshop & Advocacy Day advertised on the Division 56 listserv, I immediately submitted my application.

The day and half of training at the APA office was excellent. It was fascinating to hear psychologists at different career stages with varied specialties talk about their involvement in shaping important mental health-related



policies. I also appreciated the practical strategies and “tricks of the trade” that we learned for speaking with Members of Congress and their staffers. Because of my commitment to human rights, I was excited we were advocating for legislation that would provide greater protection for pregnant incarcerated women—a population that has received little attention in both the popular press and the academic literature.

The visit to The Hill was exciting. Along with a few other California-based psychologists, I met with staff in the offices of Senators Feinstein and Harris, and staff in the offices of three representatives from different districts in California. I was encouraged by their openness to hearing our position on the treatment of pregnant incarcerated women. We utilized our knowledge of the trauma literature to build the case for the importance of this legislation. Through the process, I realized that staff were interested in talking with us not only because of our professional expertise, but also because we are their constituents. More specifically, the congressperson for whom he or she works needs our vote! In these challenging times, it is easy to become overwhelmed by the multitude of problems in our society. Yet, I find solace in knowing that we can make our voices heard on key issues by speaking to our elected officials. We can be even more influential when we collaborate with our professional associations in advocating for change. I finished The Hill visit feeling empowered and inspired. Since then I have already been to Sacramento to advocate for local legislation, and will continue to do so at the state and national level.

### **Christopher DeCou, PhD**

I recently completed my PhD in Clinical Psychology at Idaho State University, and am now a Postdoctoral Fellow at the University of Washington, Harborview Injury Prevention and Research Center. My research and clinical interests center on the study and prevention of suicide, including the association between violence and suicidality. Prior to graduate school, I was employed as a police officer, and also served as a volunteer firefighter/EMT. These experiences as a first responder, and my research with incarcerated women during graduate school, have highlighted for me the importance of addressing the intersection of public policy and psychological science for those who are under-resourced, trauma-exposed, and suffering symptoms of psychopathology, and thus I was very motivated to participate in the recent Advocacy Training and Capitol Hill visit sponsored by APA, which sought to advance legislation to end the shackling of pregnant women in custody.



*Jessica Lambert, PhD, on Capitol Hill*

As Jessica noted above, the advocacy training offered was exceptional and very effectively conveyed the complexity of policy work, as well as the ways in which psychologists who are not policy experts can make tangible contributions to policy issues. There were two points offered by the APA Government Relations staff and other speakers that stood out to me the most. First, advocacy is a process that all psychologists can engage in directly by calling, writing, and visiting their elected officials, particularly during times that elected officials are on recess from Congress and spending time in their home districts. Next, it was empowering to learn about the role of legislative staff who work with different lawmakers and committees, and to learn how staffers are key points of contact and access when working to advocate for particular legislative issues.



*Christopher DeCou, PhD*

To put this training into practice during the Capitol Hill visit, I met with the staff of Senators Murray and Cantwell, as well as staff for Representatives Jayapal, Kilmer, and Reichart. It was very meaningful to have the opportunity to help orient lawmakers' staff to the empirical literature concerning trauma exposure and psychopathology among women in custody, and also to note the potential benefits of trauma-informed care and prohibiting the use of restraints in this particularly vulnerable population. Having training and support throughout this process has shown me that advocacy is an important and accessible pursuit for me as a psychologist, and I look forward to contributing to future advocacy efforts related to this and other important policy issues of relevance to trauma survivors, including those who are incarcerated.

# It's Not All Black or White: Response to Shedler's Psychology Today Blog "Selling Bad Therapy to Trauma Victims"

Christine A. Courtois, PhD, ABPP

I write this blog response as a clinician with over 40 years of experience (just retired from practice) and an author/trainer who has devoted my career to the development of treatment approaches for different types of interpersonal trauma. I have recently served as Chair of the American Psychological Association Clinical Practice Guidelines for the Treatment of PTSD in Adults (2017) (the subject of Dr. Shedler's critique) and over the years have helped develop other professional practice and clinical practice guidelines. I have also long called for the inclusion of the topic of trauma and trauma practice into professional curricula across all professions (Courtois & Gold, 2006) and helped to organize an APA Division 56 (Trauma Psychology) project on competencies in trauma treatment that has resulted in a set of training guidelines (Cook et al., 2014). My interests have very much been focused on not further burdening or harming clients suffering from the effects of trauma.

From my perspective, Dr. Shedler took a very extreme position in response to the APA Clinical Practice Guidelines process and recommendations and was irresponsible in telling therapists to totally ignore this (and by association, other clinical practice guidelines). Moreover, as noted by other responders, he offered a number of ill-chosen analogies to make his points. That said, as someone who is primarily a clinician and a member of the Guideline Development Panel, I well understand the struggles of both clinicians and patients to reconcile guideline treatment recommendations while not losing clinician wisdom, judgment, and patient preference, values, and contextual issues in the process. The recommended treatments have always seemed too narrow in scope to me but they are but one important determination in what should be broad-based treatment. I too have worried that third parties, especially insurance companies, will over-rely on guideline recommended treatments as applicable to all trauma clients at whatever point they are in the treatment process and that my clinical recommendations will be ignored and dismissed. It is my belief that all of the clinicians who served on the panel struggled with these issues in one way or another. And all were concerned about what works and doesn't in treating trauma and its aftermath (as Dr. Shedler is as well). As discussed below, issues such as these are

discussed in the APA guideline document and why a Professional Practice Guideline is being prepared to accompany clinical practice guidelines.



Christine A. Courtois,  
PhD, ABPP

Rather than ignore and trash the entire guideline effort as Dr. Shedler suggests, therapists should be encouraged to view Clinical Practice Guidelines as sources of information regarding the efficacy of various treatments. There are now a number of such guidelines that have been produced by professional organizations and groups (nationally and internationally [see listing in Appendix A]) and these can be cross-referenced by the interested clinician. They can also be supplemented by other authoritative and peer-referenced writings and by Professional Practice Guidelines that outline the needs of a special population or issue that range well beyond efficacy studies only. These are written specifically to assist the practicing clinician to anticipate and manage more process-related interpersonal (transference, countertransference, vicarious trauma and vicarious resilience issues among them), contextual (diversity and generalizability) and content issues. APA (2016) has specified the differences in the two types of guidelines.

Controversies about evidence-based practice in psychology have been ongoing and are likely to continue. In response to the polarization of viewpoints, APA has identified three "legs of the stool" for evidence-based practice, in the process distinguishing itself from other behavioral health professions: 1) empirical evidence derived from research findings (Randomized Clinical Trials best for determining efficacy yet other methods relevant for important questions); 2) clinical judgment (including knowledge of the client's condition and needs); 3) client preference, values, and context (American Psychological Association, 2006). As Dr. Shedler (and many other writers) correctly note, RCT's are not perfect nor are they without weaknesses and the body of high quality RCT's for the treatment of trauma symptoms is limited at this point (as was pointed out in the guideline document). Moreover, it is recognized that political and social issues and past research findings in support of a particular treatment may make research funding for the newer methodologies hard to come by, leading to possible bias and to asymmetry in the approaches that are funded for research. And, no doubt, shorter-term treatments lend themselves to being easier to research. Panel members made many recommendations for filling in research gaps



in future efforts and it should be noted that research studies are becoming more sophisticated over time.

A presentation at the recent annual conference of the International Society for Traumatic Stress Studies (ISTSS) entitled “Clinical Practice Guidelines: Are They Still Clinical?” (Kudler et al., 2017) stressed the need for balance among sources of information and cited the importance of various knowledge sources and types of research and ongoing innovation. Various organizations including Division 12 of APA and the National Register of Evidence-Based Practices and Procedures (NREPP, SAMSHA) have produced listings of evidence-suggested and evidence-based practices that are not always based on RCT’s and thus are not as rigorously evaluated as in a systematic review but are valuable nonetheless in providing clinicians with information about treatments that are emerging and have some research evidence to support them. At the present time, there are also efforts underway to otherwise discern the efficacy of emerging treatments (See Metcalf et al., 2016 review of RCT’s for emerging therapies). Notably, several of these are physiologically-based treatments and offer preliminary evidence in support of the current emphasis on mind-body treatment of trauma.

### **The Institute of Medicine standards for developing Clinical Practice Guidelines guided development of the APA *Clinical Practice Guidelines for the Treatment of PTSD in Adults***

Below is a brief outline of the process that was followed by the APA Guideline Development Panel so that readers know it was not a “fly-by-night” effort and that it involved extensive evaluation and consideration. A more detailed description can be found in the document itself and in the article by Hollon et al. (2014).

Over the past decade, the leadership of APA determined a need for the development of high-quality clinical practice guidelines in keeping with those produced by other national and international health professions. A decision was made to rely on the process developed by the Institute of Medicine (2011a & b), the current “gold standard” by which clinical practice guidelines are developed, obviously quite a change and a challenge for APA. The treatment of PTSD was among the original three topics to be proposed and approved for clinical practice guideline development. An eleven member multidisciplinary group of experts in various aspects of PTSD treatment and research methodology and two consumer members was convened in 2012. As part of the transparency process, nominees completed extensive conflict of interest disclosures (financial as well as theoretical/intellectual). No developers of treatments were members of the panel, although it was acknowledged and encouraged that members would have differences in theoretical orientation and perspectives to bring to the discussions. The PTSD panel was the first to complete a process that lasted more than 4 years due to the learning curve regarding

the methodology (for both supporting staff and members of the panel) and to have its guideline accepted by the APA Council of Representatives (February 2017).

The primary evidence base for the guideline was the systematic review of the treatment literature, *Psychological and Pharmacological Treatments for Adults with Post-traumatic Stress Disorder (PTSD)* (Jonas et al., 2013) produced for the Agency for Healthcare Research and Quality (AHRQ) by the Research Triangle International-University of North Carolina Evidence-Based Practice Center (RTI-UNC EPC). The comprehensive and transparent systematic review of available RCT’s addressed psychological and pharmacological treatments for PTSD. It addressed the following Key Questions: 1) What is the efficacy of psychological and medication treatments for adults with PTSD, compared to no treatment or to inactive controls? 2) What is their comparative effectiveness (i.e., psychological treatments compared to other psychological treatments, medication treatments compared to other medication treatments, and psychological treatments compared to medication treatments)? 3) Which treatments work best for which patients? In other words, do patient characteristics or type of trauma modify treatment effects? 4) Do serious harms of treatments or patient preferences influence treatment recommendations?

The review followed the protocol set forth by the Institute of Medicine (2011b) of first identifying hundreds of studies and determining whether studies met the inclusion/ exclusion criteria then a detailed evaluation of the quality of the studies in terms of risk of bias, precision, consistency, and directness. The stringency of the evaluative process resulted in a high exclusion rate, a limited number of studies on which to base recommendations, and thus to more restricted findings. Once the studies were compiled and analyzed, panel members conducted a detailed review and independent analysis of the findings. They considered four factors as they drafted recommendations: 1) overall strength of the evidence; 2) the balance of benefits vs. harms/burdens; 3) patient values and preferences; and 4) applicability. Based on the combination of these factors, the panel made a strong or conditional recommendation for or against each particular treatment or made a statement that there was insufficient evidence to be able to make a recommendation for or against.

The following *recommendations* were made for treatment interventions for adult patients with PTSD (listed in alphabetical order): cognitive behavioral therapy (CBT), cognitive processing therapy (CPT), cognitive therapy (CT), and prolonged exposure therapy (PE). The panel *suggested* brief eclectic psychotherapy (BEP), eye movement desensitization and reprocessing (EMDR), and narrative exposure therapy (NET). For medications, the panel *suggested* offering the following (in alphabetical order): fluoxetine, paroxetine, sertraline, and venlafaxine. With some exceptions, the APA PTSD treatment guideline recommendations and suggestions are

consistent with guideline recommendations previously published by other professional associations and organizations. Therefore, at the present time, research support is most available for CBT-based techniques; however, techniques such as EMDR--based on additional type of processing beyond the fear and cognitive processing of CBT--and Brief Eclectic Psychotherapy that works largely from a psychoanalytic and psychodynamic base received conditional recommendation.

In the section on research gaps and in the guideline summary, the panel noted that the available PTSD treatment research is substantial but requires increased sophistication in design and methodology to study the expanded range of treatments that are now available. Panel members support the ongoing research pertaining to treatment process, outcome, and relational dimensions, in general and as it applies more specifically to work with traumatized individuals, and hope to have it incorporated in future guidelines. These guidelines will be reviewed in five years following adoption as policy with a decision to update, revise, or sunset the document made at that time. It is of note that the Agency for Healthcare Research and Quality has commissioned additional systematic reviews on psychosocial treatments and psychopharmacology for PTSD that may provide the data for revision to the guidelines.<sup>1</sup>

The draft of the guideline document was posted for a two months' public comment period that resulted in more than 800 responses, many of them from clinicians whose concerns were similar to those expressed by Dr. Shedler. These were reviewed and responded to individually or in aggregate by the panel. Parts of the guideline were modified in response to the comments and the final document was presented to the APA Council of Representatives at its February 2017 meeting. In accepting the guideline, Council members suggested a "preamble" be written highlighting certain key issues and this document was written and posted with the guideline (see [Placing Clinical Practice Guidelines in Context](#).) Throughout the guideline and this context document, it is noted that guidelines are not standards nor mandatory and that they are aspirational. Clinicians are advised to be familiar with guidelines and to incorporate them into their treatment plans as they determine their recommendations' applicability to a particular client and clinical situation. In addition, and in response to clinician concerns and also to the fact that these guidelines are narrowly directed to the reduction of symptoms of PTSD on the basis of a highly-vetted set of RCT's, the Council directed a companion Professional Practice Guideline (PPG) to address many of the issues and concerns related to good clinical care of trauma survivors not addressed by the CPG

I hope this brief overview provides rationale for the process and the findings. Rather than ignore them or to treat them as "bad therapy", I encourage clinicians to use them in informing their traumatized clients about what treatments have been found to work so far in reducing symptoms of PTSD and in helping them evaluate and select interventions. They can also discuss other more process-oriented, psychodynamic, and relationally-based techniques that are routinely used for the other clinical concerns found in many of these clients who have comorbid diagnoses and issues related to their identity and self-worth, including shame, guilt, responsibility, morality, and spirituality and some are highly dissociative. Clinicians have been highly creative in developing innovative techniques to treat the range of posttraumatic stress disorders. Now research needs to catch up--clinical researchers need to continue the development of innovative and rigorous methodologies to study these emerging treatments as to their efficacy, effectiveness, and applicability. Trauma survivors deserve nothing less.

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# Intensive Outpatient Prolonged Exposure for PTSD in Post-9/11 Veterans and Service-Members: Program Structure and Preliminary Outcomes of the Emory Healthcare Veterans Program

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Exposure-based psychotherapies are highly effective and strongly recommended by APA and VA/DOD Clinical Practice Guidelines as first-line treatments for posttraumatic stress disorder (PTSD) (American Psychological Association, 2017; VA/DOD, 2017). Unfortunately treatment completion rates, particularly among Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) veterans and service members, are low, with 30 to 46% of patients dropping out (Kehle-Forbes, Meis, Spoont, & Polusny, 2016; Mott et al., 2014). New approaches to improve retention of patients in empirically-supported therapies (ESTs) for PTSD are needed.

Recent evidence suggests that having fewer days between sessions may be associated with better outcomes in ESTs for PTSD (Gutner, Suvak, Sloan, & Resick, 2016). While no randomized controlled trials directly comparing massed sessions, which usually occur daily, to spaced or weekly sessions (the current standard) for exposure-based therapy for PTSD have been published, a case study has demonstrated good outcome from a massed two-week course of Prolonged Exposure therapy (PE) for PTSD (Blount, Cigrang, Foa, Ford, & Peterson, 2014) and multiple studies have demonstrated excellent results from massed treatments for other fear-based disorders (e.g. specific phobia; Ost, Brandberg, & Alm, 1997; Ost, Alm, Brandberg, & Breitholtz, 2001). Extant studies comparing outcomes from massed vs. spaced ESTs for depressive and anxiety disorders have demonstrated similar long-term outcomes but shown that massed treat-

ments are associated with faster rates of improvement (Cuijpers, Huibers, Ebert, Koole, & Andersson, 2013; Storch et al., 2008). This increased speed of recovery may be particularly important for post-9/11 veterans and service members who may be hesitant to complete longer-term treatments due to employment and family responsibilities or deployment and duty-station changes. Furthermore, massed sessions may reduce the likelihood

of avoidance, a core symptom of PTSD which can interfere with motivation to complete treatment, as patients may see improvements sooner and have more frequent contact with service providers who can help them label and effectively counter avoidant tendencies.

Intensive treatment programs for PTSD, which include frequent sessions and multiple forms of provider support, are one possible strategy for improving engagement, dropout rates, and treatment outcomes for veterans and service members. The Emory Healthcare Veterans Program (EHVP) is a two-week intensive outpatient program (IOP) that offers daily PE and clinically indicated adjunctive interventions. The IOP was created as an alternative or adjunct to traditional outpatient treatment in order to enhance treatment completion and provide comprehensive, focused, multidisciplinary care to military veterans and service members with PTSD across the country. The EHVP is part of the Warrior Care Network that is funded by the Wounded Warrior Project (WWP) and currently includes four treatment programs focused on the invisible wounds of war [<https://www.woundedwarrior-project.org/programs/warrior-care-network>]. The EHVP IOP program offers treatment to qualified post-9/11 veterans and service members free of charge (i.e., all costs not paid for by patients' insurance are paid by WWP).



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## Program Structure

IOP patients are referred from a vari-



ety of sources, including WWP, federal and private mental healthcare providers, and self-referral. To determine fit and eligibility, interested veterans and service members complete self-report questionnaires and a two-hour intake assessment (via telehealth or in person), which includes semi-structured interviews of PTSD symptoms (the Clinician Administered PTSD Scale for DSM-5; Weathers, Blake, et al., 2013) and other psychiatric disorders (Mini International Neuropsychiatric Interview; Sheehan et al., 2015) and collection of service, medical, psychosocial, and treatment history. Appropriate IOP patients are those for whom PTSD is the primary presenting concern and who are sufficiently medically and psychiatrically stable to participate in intensive trauma-focused treatment. Program acceptance and treatment planning is completed by a multidisciplinary team based on assessment results and review of medical records.

The primary goal of the program is to reduce PTSD symptoms through intensive individual and group therapy and enhance maintenance of gains through engagement with adjunctive treatments. This two-week program utilizes a modified intensive outpatient approach to Prolonged Exposure therapy (Blount et al., 2014) that was adapted from a group-based version (Smith et al., 2015). This approach involves daily individual imaginal exposure (repeated visiting of trauma memories in the imagination) and daily group *in vivo* exposure (repeated confrontation of objectively safe, trauma-related situations that the patient avoids). Common *in vivo* exposure targets for post-9/11 veterans and service members include crowded public places (e.g., malls, large retail stores, festivals), sitting with one's back toward open spaces or other people, loud or sudden noises, and being in the presence of smells, people, or places that are reminiscent of the Middle East (e.g., smells of certain spices, people wearing traditional Islamic dress). Exposure takes places both within the office, for targets that are easily accessible such as imaginal exposure or recorded auditory and visual stimuli, or outside of the office, for targets such as crowded public places. The goal of both imaginal and *in vivo*



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exposure strategies is to facilitate extinction of fear responses through corrective learning and generate adaptive perspectives of the trauma, self and others, and the future.

Each weekday while in the program, patients complete one 90-minute individual imaginal exposure session and one 120-minute group *in vivo* exposure session. Additionally, patients are assigned daily out-of-session practice exercises, including *in vivo* exposure and listening to imaginal exposure recordings. All IOP patients are assigned to a social worker who provides individualized case management and support, and regular team communication occurs between the individual therapist, group leader, and case manager to coordinate treatment planning and to provide updates regarding progress. In addition, patients are involved in recreational activities during the week and on the weekend with veteran outreach coordinators, combat veterans who provide peer support and camaraderie throughout the program. Potential adjunctive services, usually occurring one to three times each per week while in the program include (but are not limited to) family treatment, medication management, yoga, cognitive assessment and rehabilitation services for traumatic brain injury, sleep assessment and intervention, and pain assessment and intervention. These services provide a holistic, integrative, and individualized approach to supporting patients as they complete PTSD-focused treatment and prepare to maintain gains after treatment.

## Results

The IOP opened in February 2016. Between February and December 2016, 49 patients entered the program. Patients averaged 40.67 years of age ( $SD = 7.84$ ) and 71% were male. The majority served for the Army (67%), followed by the Marine Corps (12%), Navy (12%), Air Force (6%), and multiple branches (2%). Most patients had been separated from the military (41% discharged, 22% retired, 20% medically retired). Only 12% were active duty and 4% were in the Army National Guard. Traumatic experiences targeted during therapy were primarily

combat and military sexual traumas. Of the 49 patients who began the program, 42 received an adequate dose of PE, defined as either completing two weeks of individual and group PE or demonstrating significant gains prior to the end of the two weeks (e.g., sufficient habituation to trauma memory and avoided stimuli). Of the seven who did not, five patients (10%) were determined not to have primary PTSD upon arrival, and therefore alternative treatment approaches (e.g., cognitive behavioral therapy for depression or anxiety) were used. Two patients (4%) did not complete the program: one (2%) dropped out of treatment and another (2%) violated program rules and was discharged early.

To assess treatment outcome, symptom severity was measured at baseline (day 1) and completion (day 13). Severity of PTSD symptoms over the past week was measured with the PTSD Checklist for *DSM-5* (PCL-5; Weathers, Litz, et al., 2013) and severity of depressive symptoms over the past week was measured with the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001). Data at baseline and completion were available for 30 patients who received an adequate dose of PE.

We first calculated reliable symptom reduction, defined as statistically significant change in symptom severity on the PCL-5 and PHQ-9 (i.e., change  $\geq 1.96$  the standard error of difference between two time points). Fifty-three percent of patients ( $n = 16$ ) who completed the IOP PE exhibited reliable reduction in PTSD symptoms over the two-week treatment period and 37% ( $n = 11$ ) exhibited reliable reduction in depression symptoms. Using traditional PCL-5 cut-scores to screen for a PTSD diagnosis, 80% of patients were marked as positive at baseline and 43% were marked as positive at treatment completion. Using traditional PHQ-9 cut-scores to screen for a major depressive disorder, 90% of patients were marked as positive at baseline and 47% were marked as positive at treatment completion. The baseline-completion effect sizes were large for PTSD (Cohen's  $d = 1.31$ ) and depression (Cohen's  $d = 1.25$ ). Lastly, in an anonymous survey at treatment completion, 95% of patients reported overall satisfaction with the program and 84% reported that treatment improved their clinical concerns.

## Conclusion

Initial outcome data suggests that a PE-based IOP model of treatment for PTSD in veterans leads to large improvements in PTSD and depression symptoms in two weeks. These improvements are comparable to those found in standard outpatient PE but occurred in a much shorter time (two weeks vs. at least 8-12 weeks). Furthermore, treatment dropout was notably lower in the current sample than in comparable samples of outpatient PTSD treatment for OEF/OIF/OND veterans (4% vs. 30-45%). Given concerns from some clinicians regarding patients' ability to tolerate exposure therapy for PTSD (Ruzek et al., 2016), it is notable that almost

all patients were able to complete intensive daily PE and most demonstrated strong benefit from treatment and reported very high treatment satisfaction. The current results are limited by small sample size and lack of a control group, both of which should be addressed in future research. Despite these limitations, our findings suggest that the EHVP IOP model might provide a new, effective, and highly efficient way to treat veterans and service members with PTSD.

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**Dr. Carly Yasinski** is a Postdoctoral Fellow in clinical psychology at the Emory Healthcare Veterans Program at Emory University School of Medicine. Dr. Yasinski earned her PhD from the University of Delaware and completed her clinical internship at the Medical College of Georgia and Charlie Norwood VA Medical Center consortium in Augusta, Georgia. Dr. Yasinski's clinical interests are in cognitive-behavioral and mindfulness-based approaches to treating depression and PTSD. Her research interests focus on better understanding the process of change during psychotherapy for these disorders.

**Dr. Andrew Sherrill** is a postdoctoral fellow in clinical psychology at the Emory Healthcare Veterans Program at Emory University School of Medicine. Dr. Sherrill earned his PhD from the Northern Illinois University and completed his clinical internship at Veterans Affairs Puget Sound Health Care System, American Lake Division. Dr. Sherrill's clinical interests include exposure- and mindfulness-based treatments for emotion dysfunction, namely PTSD. His research leverages theories and methodologies from cognitive psychology to better understand the etiology and treatment of trauma-related psychopathology and problematic aggression.

**Dr. Jessica Maples-Keller** is a postdoctoral fellow at Emory University School of Medicine with the Emory Healthcare Veteran's Program and the Grady Trauma Project. Dr. Maples-Keller earned her PhD

from the University of Georgia and completed her clinical internship at the Medical University of South Carolina. Her research interests include investigating factors that confer risk or impact treatment response for PTSD and anxiety disorders and how translational models of fear and anxiety can be used to understand and improve exposure therapy.

**Dr. Sheila A. M. Rauch** is an associate professor in the Department of Psychiatry and Behavioral Sciences at the Emory University School of Medicine. She also serves as a Prolonged Exposure Therapy Roll Out Trainer with the Department of Veterans Affairs. Her research focuses on translational treatment outcomes and modifications of proven treatments for use in alternate settings, such as primary care. She has published scholarly articles and book chapters in the areas of anxiety disorders and PTSD focusing on neurobiology and factors involved in the development, maintenance, and treatment of anxiety disorders, psychosocial factors in medical settings, and the relation between physical health and anxiety.

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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](mailto: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**

**div56childtrauma@lists.apa.org**

**div56dissociation@lists.apa.org**

**div56ecpn@lists.apa.org**

**div56stu@lists.apa.org**

for discussion among members

for child trauma topics

for post-traumatic dissociative mechanisms development

for early career psychologists networking

for student forum

# A Brief Review of the Conservation of Resources Theory as It Applies to Military Trauma

*Jordan Joyner, MS & Valerie Leake, PhD, LCP*

The Conservation of Resource Theory (COR; Hobfoll, 2001) has been found to be a reliable basis for understanding the processes involved with experiencing, coping with, and overcoming chronic and traumatic stress (Hobfoll et al., 2001). The COR theory postulates that individuals are motivated to protect, procure, and preserve resources (Hobfoll, 1991). Resources are anything that a person values and can be broken down into four categories: objects (e.g., house, phone), conditions (e.g., stable employment, good health), personal characteristics, (e.g., optimism, hope), and energies (e.g., knowledge). According to the COR theory, stress results when an individual's resources are threatened, depleted, or when investment(s) in new resources do not accrue adequately (Hobfoll, 1991; Hobfoll, 2001). Hobfoll (1991) proposed that traumatic stress results from an accelerated loss of resources, particularly those that are most valued by the individual. Compared to civilians, United States (U.S.) military personnel have a greater likelihood of experiencing combat trauma through deployment or work-related responsibilities (King et al., 1999; Hobfoll et al., 2012). In recent years, there has been a surge of deployments to active war zones, increasing the frequency of combat trauma. A statistical report of military and civilian casualties related to the U.S.' involvement in wars/conflicts from 2000 to 2015 found higher rates of PTSD among deployed personnel. The majority of PTSD diagnoses in the military, 77.87%, were among men and women who were previously deployed (Fischer, 2015). These findings indicate the need for continued examination of combat trauma and its impact on a service member's resources. A brief review of how COR theory applies to military trauma is provided.

Military trauma is a broad term that encompasses unexpected and stressful events unique to service members. Military trauma can include combat, terrorism, and military sexual trauma (National Center for PTSD, 2017). Although prior

research has determined that the majority of service members adapt well across the lifespan, chronic mental health issues such as posttraumatic stress disorder (PTSD) and depression are commonly associated with

traumatic events among these individuals (Hobfoll et al., 2012). This may be due to the impact traumatic events have on an individual's resources (Hobfoll, 1991; King et al., 1999), as they challenge current coping capabilities (Hobfoll et al., 2012).

Traumatic or extreme stressors are unique in that 1) they attack individuals' core values, 2) they are often unanticipated, 3) they require significant energy, 4) typical coping strategies are ineffective, and 5) a strong mental image regarding the event is imprinted on the individual (Hobfoll, 1991). Resources, such as social support, well-being, and optimism become increasingly difficult to utilize, protect, and maintain following a military trauma. Three principles guide COR theory as it applies to traumatic stress.

The first principle of COR theory states that resource loss has a significantly stronger impact on the individual than resource gain (Hobfoll, 1991; 2001). For example, should a service member lose a comrade in battle, receiving a medal to recognize his/her exemplary efforts during the battle would not mitigate the loss of a friend. Resource loss has been found to be significantly associated with psychological distress (Hobfoll et al., 2012; Vogt et al., 2011), whereas resource gain has a restricted impact on psychological distress (Hobfoll & Lilly, 1993). Hobfoll and colleagues (2012) examined the impact of family life, work, and war-related stressors on PTSD symptoms, depression, and perceived health and functioning in a large sample of Air Force men and women. Collectively, the stressors directly affected symptoms of PTSD and depression. Of significance was the finding that larger stressors predicted increased resource loss and reduced resource gain. Resource loss further predicted PTSD symptom severity and levels of perceived distress. Similarly, King et al. (1999) found direct links between



*Jordan Joyner, MS*



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pre-trauma, war-zone, and post-trauma experiences and PTSD. They suggested that pre-trauma life experiences may have depleted the individual's ability to cope with stressors later in life. These findings support the argument that resource loss outweighs resource gain.

In the second principle, individuals must invest in resources in order to prevent and restore resource loss, as well as acquire new resources. This principle is typically studied in research concerning coping, indicating that resource investment is a coping mechanism meant to prevent future losses (Ito & Brotheridge, 2003). For example, a person must reach out to friends/family in times of stress in order to receive social support (Hobfoll et al., 1995). By investing in resources, an individual is able to cope more effectively with stressors.

This principle also has been supported in the context of military trauma. Just as service members learn how to apply their skills in a variety of conditions and settings, they also must learn how to adjust to traumatic circumstances by investing resources in an effort to overcome the impact of a traumatic event. For example, those who utilize (i.e., invest) social support (i.e., a resource) are less likely to develop PTSD (King et al., 1999; Vogt & Tanner, 2007). Similarly, hardiness, a personality characteristic that entails effectively coping with everyday stressors, appears to be a protective factor against deployment stressors (Vogt et al., 2008). However, these resources are likely to be depleted in the aftermath of military trauma (Vogt et al., 2008). Investing in resources is likely to assist a service member in protecting current resources, assisting in the acquisition of new resources, and preventing future loss of resources.

The third principle involves loss and gain spirals (Hobfoll et al., 1995). As stated in the first principle resource losses are more influential than resource gains, with gains requiring more time and energy. Loss spirals result from the ongoing cycle of a rapid depletion of resources, with the opposite being true for gain cycles (Hobfoll et al., 2001, Hobfoll et al., 2015). The loss of resources contributes to trauma reactions, which, in turn, give rise to the loss of additional resources (Johnson et al., 2007). This downward cycle is believed to continue and build on itself (Hobfoll et al., 1995).

In the wake of a traumatic event, individuals lose resources such as a sense of well-being, optimism, or trust (Hobfoll, 1991). People have fewer and/or less effective resources to cope with new challenges (Hobfoll et al., 1995), making the impact of a future stressor that much stronger. Researchers have confirmed that multiple chains of risk explain the development of PTSD (King et al., 1999; Vogt & Tanner, 2007). Life experiences prior to, during, and after military involvement also may augment the impact of stress on an individual, which minimize resources and, in turn, increase veterans' risk of experiencing another stressor (Vogt et al., 2011). More specifically, childhood traumatic experiences may mean

a loss of resources early in life that predict a greater risk for exposure to stressors later in life, as well as less access to appropriate resources that prevent losses (Vogt et al., 2011). When considering post-deployment experiences, exposure to additional life stressors, such as job interruption or criminal victimization (King et al., 1998), and a lack of social support (King et al., 1999) suggests a loss of resources that makes adjusting to life after deployment challenging (Vogt et al., 2011). For example, family instability during childhood and perceived threat in combat were associated with experiencing additional stressors in Gulf War veterans (Vogt & Tanner, 2007). Similarly, in a sample of U.S. Air Force personnel, symptoms of PTSD predicted future loss of resources, as well as a decline in perceived health and functioning (Vinokur et al., 2011). The minimization of resources over time resulting from repeated exposure to traumatic events provides evidence for loss spirals, as outlined by COR theory (Hobfoll, 1991; Hobfoll et al., 1995).

The basic tenets of COR theory provide a framework for understanding the development of traumatic stress. When examining the impact of military trauma, it is clear that a loss of resources contributes to a host of negative outcomes, such as PTSD and depression (King et al., 1999; Vogt et al., 2011). These findings are consistent with the COR theory. The COR theory contributes to the field of trauma psychology, by providing guidance for treatment programs for veterans by promoting the exploration of both protective and risk factors for the development of traumatic stress. By increasing our understanding of resources and how resources assist in coping with military trauma, we are better able to meet the needs of veterans.

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**Jordan Joyner** obtained her master's degree from Tennessee State University, and is currently a doctoral student in Radford University's Counseling PsyD program. She is completing her third year practicum placement with the Salem, VA Veterans Affairs Hospital in the inpatient PTSD and substance abuse units. Jordan's research interests include trauma, resilience, and the military. She is team leader of a veteran's

research team, and has co-created a veteran-specific orientation course that will begin in Fall 2017. Jordan is also currently assisting with a grant application. Her long-term career goal is to treat trauma in the military population.

**Dr. Valerie Leake** received her PhD in Counseling Psychology from University of Kentucky. She began teaching at Radford University in 2007. She has specialized training with the veteran population, serving for two years as the PTSD Clinical Team/Evidence-Based Psychotherapies Coordinator for the Lexington, KY Veterans Affairs Hospital before becoming the Training Director of Radford University's Counseling PsyD program in 2016. Dr. Leake has initiated a student veterans research team, established Radford University as a co-host for the 2017 Rural Behavioral Conference, and spear-headed grants specific to military psychology. Her research interests include trauma, veterans, and counseling services in rural areas.



# International Committee

*Elizabeth Carll, PhD*  
*Vincenzo Teran, PsyD*

As part of the series of interviews conducted by student members with trauma psychologists from various parts of the world, **Rayna Sanghvi** a student member of the International Committee interviewed, **Dr. Leonidas Castro-Camacho** a clinical psychologist based in Bogotá, the capital city of Colombia. He is in private practice and also an associate professor at the University of Los Andes.

The interview series with distinguished trauma psychologists from around the world provides our students with the opportunity to meet psychologist role models from many cultures. The interview article, which is below, provides a window into the work of trauma psychologists globally and enables a better



*Elizabeth Carll,  
PhD*



*Vincenzo Teran,  
PsyD*

understanding of cultural issues relating to psychology.

To encourage participation of international students at the APA convention, the Division approved an annual \$1000 student stipend and complimentary convention registration to support travel of a student from a developing country, who has a trauma related poster or paper accepted for the presentation at the convention. The 2018 APA Convention will take place in San Francisco. A free one year membership in Division 56 is also included. Interested candidates for the travel stipend should contact: Dr. Elizabeth Carll, at [ecarll@optonline.net](mailto:ecarll@optonline.net) and Dr. Vincenzo Teran at [vincento.teran@gmail.com](mailto:vincento.teran@gmail.com).

With the emerging immigration crisis occurring globally, the Refugee Mental Health Resource Network, an APA Interdivisional project is reported in another section of the newsletter.

## An International Committee Interview with Leonidas Castro-Camacho, PhD, ABPP

*By Rayna Sanghvi, BA*

Dr. Leonidas Castro-Camacho is a clinical psychologist based in Bogotá, the capital city of Colombia. Dr. Castro-Camacho received his Ph.D. in clinical psychology from Stony Brook University, in New York, USA and returned to Columbia to develop evidence-based psychological approaches for trauma psychology in his country. After all his years of hard work, Dr. Castro-Camacho is a force to be reckoned with. This is demonstrated by the various professional roles he plays. Dr. Castro-Camacho runs a private practice where he provides therapy to almost 30 patients a week. Additionally, he is an associate professor at the esteemed University of Los Andes where he teaches various undergraduate and graduate psychology classes related to abnormal psychology, introduction to clinical psychology, case formulation, clinical assessment, and mood disorders. At the university, Dr. Castro-Camacho provides clinical supervision and conducts research, where he also functions as a research advisor to eight students.

Currently, Dr. Castro-Camacho is running a large-scale randomized clinical trial (RCT) for over three years. This clinical trial utilizes a culturally adapted version of David Barlow's Unified Protocol for Transdiagnostic

Treatment of Emotional Disorders. Barlow's Unified Protocol focuses on the commonalities of major emotional disorders as a treatment target, rather than the differences. The protocol is targeted towards individuals who have been heavily affected by the many years of civil unrest, which is one of the world's longest armed conflicts. Various guerrilla groups, paramilitary groups, and the largest rebellion in Colombia, the Revolutionary Armed Forces of Colombia (FARC) has created havoc in the country for over 50 years. In 2016, a significant point of progress was marked as the Colombian government signed a peace agreement with FARC. However, this peace agreement is yet to be completely implemented. The armed conflict has not only results in countless deaths, but has also internally displaced over seven million people resulting in fear and trauma in their lives.

Dr. Castro-Camacho explained that most of the people who had been displaced came from rural villages, leaving their friends, family, agricultural land, etc behind, to move to the cities to live in impoverished conditions. As a psychologist in the capital city, Dr. Castro-Camacho developed the RCT to cater to the mental health needs of this vulnerable population. The RCT has a sample of 100 participants in which 50 participants are provided with the Unified Protocol treatment and 50 participants are placed in the waitlist condition. Dr. Castro-Camacho's

students provide 12 weekly or biweekly sessions to the participants in the treatment condition. One of the original members of the Unified Protocol team visited Bogota from Boston to train the students after which Dr. Castro-Camacho translated the protocol to Spanish, adapted it to Colombian culture, and provided further training to his students. To maintain fidelity to the protocol, ensure high quality of treatment, and monitor its effectiveness on participants, Dr. Castro-Camacho provides weekly clinical supervision to his students.

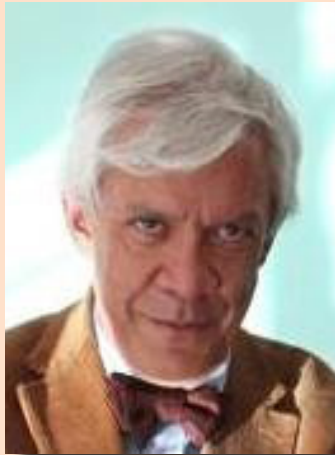
During our interview, Dr. Castro-Camacho emphasized the nature of the trauma these displaced individuals have endured and how the Unified Protocol has been adapted to address their mental health needs. It is crucial to understand that displaced people have not only suffered from one traumatic event, but in fact are victims of multiple traumas. Multiple traumas relate the harsh and exposed conditions and unsafe neighborhoods in which they live continuing to experience and witness trauma in their environment. Dr. Castro-Camacho indicated that the most common types of trauma he has seen in this population result from sexual violence, multiple rapes, physical torture, and child sexual abuse, witnessing deaths of loved ones or massacres, including seeing a family member being killed or tortured. In addition, enforced disappearances are common as well. This entails having a family member or friend being taken by FARC or members from other guerilla groups and never gaining closure as to what fate that person met with.

Dr. Castro-Camacho explained that while these displaced individuals live in unsafe conditions, they are also dealing with daily stressors such as fending for themselves, work under minimum wage conditions. Usually, in combat and conflict zones, we often see people with posttraumatic stress disorder (PTSD). However, this population, also experiences continuous threat, live with the people who have victimized them, and are at risk for future traumas as the conflict has still not ended. Thus, it is not surprising to learn that 80% of Dr. Castro-Camacho's sample meets criteria for PTSD. The second most common disorders include generalized anxiety disorder (GAD) and major depressive disorder (MDD). Dr. Castro-Camacho reports that panic disorder with agoraphobia is not uncommon. Obsessive-compulsive disorder (OCD), though rare with this population, is also present. The question arises then, how does the continuity of the armed conflict affect treatment and mitigating symptoms? Therefore, the Unified Protocol is designed not to address each disorder separately, but instead targets the

common causes for each disorder, which is suitable for this population.

Dr. Castro-Camacho has been monitoring the trial and finds that the treatment is not only producing decreases in symptoms of PTSD, anxiety, and depression, it has also increased the quality of life for these individuals as they cope with daily survival of finding or keeping a job, maintaining interpersonal relationships, and being able to leave their houses. Dr. Castro-Camacho stated that many participants have avoided returning to their villages due to the atrocities they witnessed.. However, after treatment, some of them have been able to return with the availability of better resources and safer conditions.

It is interesting to note that the attitudes towards seeking mental health treatment differ by region. Dr. Castro-Camacho conveyed that while individuals living in Bogotá are more open to seeking mental health services, there is some stigma around it and it is not as openly accepted as compared to other South American countries, such as Argentina. In the rural areas of Colombia, there are fewer resources and exposure to mental health awareness, which results in people turning to other resources such as shamans, traditional and religious healers for mental health treatment. Therefore, Dr. Castro-Camacho's adaptation of the Unified Protocol deals with the nuances of specific cultural aspects of treating trauma with this population. It is also paving the way for developing concrete evidence-based treatments for trauma, in Colombia.



*Leonidas Castro-Camacho, PhD, ABPP*



*Rayna Sanghvi, BA*

Dr. Castro-Camacho hopes to conduct further studies on dissemination if there are positive findings from Unified Protocol treatment study. This would include adapting the protocol to other modalities of treatment, such as group therapy, family therapy, and even integrating technology, so it has a wider reach. We would like to wish Dr. Castro-Camacho and his team the very best as he aims to complete the clinical trial by 2018.

**Rayna Sanghvi, B.A.,** is a Ph.D. student in the Clinical Psychology program at PGSP-Palo Alto University in Palo Alto, California. She is currently a Division 56 student committee member and campus representative. Her research interests are varied and not limited to, the early interventions for trauma, integrating technology into mental health care, and sexual trauma.





# Refugee Mental Health Resource Network

## Database Update:

### An APA Interdivisional Project

*Elizabeth Carll, PhD, Chair*

**F**orced migration due to wars, conflict, and persecution worldwide has continued to grow. The number of people displaced within their country or having fled internationally has reached more than 59 million with some statistics even higher. This is the highest level recorded according to estimates by the United Nations High Commissioner for Refugees (UNHCR).

The number of international migrants, defined as persons living in a country other than where they were born, reached 244 million in 2015 for the world as a whole, a 41 per cent increase compared to 2000.

Humanitarian emergencies, such as occurring in Myanmar, resulted in more than 650,000 refugees escaping to Bangladesh as of August 2017. The persecution of the Rohingya included the murder of adults and children, rape, and villages being burned, with the number of refugees anticipated to continue to rise.

The U.S. was the largest host country of refugees until recently when government policies changed and limited the number of refugees entering the U.S. There was a significant need for asylum evaluations and other related evaluations. With the current focus on possible deportation of undocumented immigrants, with some having lived in the U.S. for many years, there has been an increased need for evaluations focused on preventing deportation.

Mental health/psychosocial support are increasingly important components of programs for crisis affected migrants seeking asylum and refugee resettlement. There has been a great need for these services and often the demand far exceeds the supply of mental health professionals. To help meet these needs, I had proposed the development of a Refugee and Mental Health Resource Network to develop an interactive database of volunteer psychologists and mental health professionals, within the US and globally, to help fill the need for evaluations and support services. As a result Division 56 and cospon-

soring Divisions 35, 52, and 55 obtained a CODAPAR grant from APA to subsidize this project, in part. Other Divisions and state associations have since joined as collaborators.

We have been gathering the names of psychologists and mental health professionals interested in volunteering to provide services to refugees, migrants and internally displaced people. Some volunteers have experience working with refugees, and others have trauma experience.

In addition, there has been a significant interest by students who would like to receive training and volunteer to be able to help in some way. Also included are psychologists who are interested in conducting research with refugees, migrants and (IDPs). We are also gathering a list of non-profit refugee focused organizations that provide services or information.

To begin to meet the demand for training, 6 free webinars have been developed and provided in 2017 addressing various aspects of services for refugees including asylum evaluations. These webinars will be available for volunteers and additional webinars are in the planning.

The interactive database is now open for volunteers to enter their information. The application process should take about 10 to 12 minutes. Please go to:

[Volunteer Sign-up: Refugee Mental Health Resource Network](#)

Please email us at [RefMHResNetwk2@optimum.net](mailto:RefMHResNetwk2@optimum.net) for any further information. We look forward to your participation in this timely pro-bono humanitarian project.

The Steering Committee members include Elizabeth Carll, chair; Betsy Gard, vice-chair; Carl Auerbach, vice-chair; Brigitte Khoury, Elaine LeVine, George Rhoades, Vivian Ballah-Swaray.

# Using a Multicultural Framework in Trauma Psychology: Highlight of Division Resources

Shavonne J. Moore & Lesia M. Ruglass

## Multicultural Framework

As the world's population continues to become more diverse, clinicians will have to broaden their therapeutic approaches to include more than a single cultural context (Zayfert, 2008). This notion is consistent with what scholars have been saying for years, that utilizing a multicultural framework is particularly relevant and necessary (Sue, 2001), especially when it comes to culturally competent work with survivors of trauma (Brown, 2009). Trauma reactions can be broadly defined as normative responses to abnormal events. Notably, what is considered normal is subjective and largely influenced by cultural factors that affect the prevalence, impact, and healing process related to trauma, and make using a multicultural framework for working with trauma survivors imperative.

Utilizing a multicultural framework requires an understanding of how culture is relevant to the experience and treatment of trauma. Cultural influences have a bidirectional relationship with trauma in that culture and identity are tied to the experience of and recovery from trauma (Tummala-Narra, 2007). For example, there are cultural and social factors that directly influence exposure to traumatic events such as racial/ethnic disparities (Ford, 2008), sexual orientation (Roberts, Austin, Corliss, Vander Morris, & Koenen, 2010), immigration status, and geographical areas (U.S. Department of Health and Human Services, 2001). There are also cultural and social factors that influence the development of trauma symptoms and treatment outcomes (Marsella, 2010; Wilson, 2007), specifically in terms of cultural ways of coping (Tummala-Narra, 2007). For these reasons, clinicians need to understand how cultural factors, including trauma survivors' and clinicians' intersecting identities, influence the trauma recovery process (Brown, 2008; Zayfert, 2008).



Shavonne J. Moore



Lesia M. Ruglass

## Implications for Practice

What follows is a summary of key recommendations from Sue & Sue's (2016) seminal text *Counseling the Culturally Diverse: Theory and Practice* and Brown's (2008) classic text *Cultural Competence in Trauma Therapy: Beyond the Flashback*.

**Increase awareness of one's own beliefs, assumptions, and biases and how they may influence the establishment and maintenance of therapeutic relationships with culturally diverse clients:**

- We are socially conditioned through living in the United States to have certain beliefs and biases (e.g., racism, sexism, classism, ageism, ableism, heterosexism, etc.) that may influence our perceptions and understandings of clients and the therapeutic relationship.
- Clinicians should acknowledge and confront their own biases/assumptions about diverse clients and ensure that care is not negatively influenced.

**Increase one's knowledge and understanding of clients' worldviews and experiential realities, and of how this interacts with the experience of and response to trauma and the recovery process.**

- Many socially marginalized groups have common experiences with prejudice, discrimination, and stigma that may compound the trauma recovery process.
- Client's expectations and preferences for treatments should be considered during treatment planning.

**Utilize culturally sensitive assessment and intervention strategies and techniques.**

- Empirically-supported assessment and treatment strategies for trauma/PTSD may need to be tailored to meet the specific characteristics and needs of diverse populations (Schynder et al., 2016; Zayfert,



2008).

- Clinicians should be mindful of potential dynamics around cultural similarities or differences. For example, studies suggest that clinicians are prone to engaging in unintentional microaggressions against culturally different clients, which may negatively influence the therapeutic alliance and treatment outcomes (Constantine, 2007; Shelton & Delgado-Romero, 2011; Sue & Sue, 216). Clinicians should thus remain attuned to any subtle indications that there may have been a rupture in the therapeutic alliance and be willing to take the initiative to explore the interpersonal process with their client. Be open and receptive to clients' complaints about microaggressions and respond nondefensively. Validate the client's experience, clarify any misunderstandings, and accept responsibility for your role in the therapeutic rupture (Safran, Muran, & Eubanks-Carter, 2011). As Sue & Sue (2016) note "...it's how the therapist recovers, not how he or she "covers up," that makes for successful multicultural counseling" (pg. 207).
- Various cultures may have alternative/traditional healings practices and thus clinicians may need to coordinate with Native healers in order to ensure continuity and integration of care.
- Identify sources of culturally-based coping strategies or resources that bolster a sense of well-being.

## Division 56 Resources on Underserved Populations

In an effort to align with the presidential theme of Dr. Joan Cook (immediate past president), Drs. Ellis and Simiola spearheaded a project using funds from the Committee on Division/APA Relations to create relevant resources on health disparities in trauma by collaborating with other APA Divisions. These resources include printable Fact Sheets, suggested reading lists, and YouTube videos that provide empirically informed information about the prevalence, impact, and treatment of trauma among underserved health priority populations. The nine Fact Sheets examine Trauma and PTSD in Veterans, Older Adults, Male Survivors of Sexual Abuse, LGBTQ Individuals, Ethnic Minorities, Economically Disadvantaged Populations, Individuals with Intellectual and Developmental Disabilities, Children and Adolescents, and Traumatically Injured Populations (<http://www.apatraumadivision.org/633/resources-on-underserved-populations.html>).

## Connecting with the Authors

We reached out to the organizers and select authors of these aforementioned resources, with a set of questions to better understand the perceived importance and desired use of the materials. The following reflects those

interviews:

### 1. Why did you see this as an important initiative to bring to your fellow clinicians?

*It is widely known that there are large disparities in the quality of health and U.S. health care. These discrepancies exist due to myriad factors including access to health care, increased risk of disease, occupational hazards, or underlying genetic, ethnic or familial factors. They can exacerbate the effects of trauma; thus, creation and dissemination of empirically-informed psychological information on trauma survivors from underserved health priority populations were seen as particularly important by our team.*

*The factsheets and videos were specifically designed to reach clinicians, survivors, and friends and family members of those who have been impacted by trauma. While other professional organizations provide information on traumatic stress for providers and the public, that information is sometimes difficult to locate on the Internet or, when it has been identified, is difficult to access (e.g., requiring expensive membership only access). The goal of this project was to provide comprehensive, unrestricted, and free access to educational materials for clinicians, consumers, and the public.*

Drs. Amy Ellis and Vanessa Simiola  
Organizers of the Fact Sheets and Videos

### 2. Why is having a multicultural focus/framework imperative for trauma work?

*Many reasons. Trauma happens to a person with intersectional identities that are sometimes linked to historical trauma. The current trauma may land in a particular identity. Recovery strategies must be reflective of what is culturally normative for a client. Therapists need to have awareness of their own identities, privilege (or absence of), and non-conscious biases in order to work effectively with all clients, not only trauma survivors.*

Laura Brown, PhD  
Author of *Cultural Competence in Trauma Psychology*

*Having a multicultural focus when doing any type of work is important. It can be especially important during times of trauma as culture can filter into the types of traumas experienced (e.g., trauma related to immigration), cultural interpretations of the trauma, and unique cultural presentations.*

Jasmin Llamas, PhD  
Author, *Trauma & PTSD in Ethnic Minorities Fact Sheet*

*Having a multicultural focus means being deliberate in one's awareness and openness of all aspects of cultural*

identity. For this reason, I rely on Hays' (1996) ADDRESSING model, which considers age, developmental and acquired disabilities, religion, ethnicity, socioeconomic status, sexual orientation, indigenous group membership, nationality, and gender as factors relevant to an individual's unique experience of cultural identity. In working with trauma and LGBTQ individuals, it's important to consider how these factors intersect with one another and may increase risk and vulnerability to exposure to trauma and to experiencing deleterious effects of trauma, and may continue to perpetuate traumatic experiences and sequelae.

Amy E. Ellis, PhD

Author of *Trauma & PTSD in LGBTQ Individuals Fact Sheet*

### 3. How does this importance manifest in your work with clients?

In working with LGBTQ individuals, the presenting problem can range from something related to being a member of the LGBTQ community (e.g., victim of a hate crime) or non-related (e.g., childhood sexual abuse survivor, complex bereavement, or survivor of a natural disaster). But beyond that there can be an entire micro and macro system of trauma, oppression, and stigmatization that has contributed to their lived trauma experience. As a therapist, this means addressing the trauma(s) that brought them to session, and the traumas that they experience on a daily basis or have faced throughout their lifetime. These are the traumas that influence their legal rights with marriage, divorce, hospitalization, and adoption; the traumas that exist in everyday microaggressions; the traumas that result from the aftereffects of the Orlando Pulse shooting, the ban on transgender individuals serving in the military, or the ban on transgender individuals using a particular restroom.

Amy E. Ellis, PhD

Author of *Trauma & PTSD in LGBTQ Individuals Fact Sheet*

Researchers **MUST** proactively do more to look into the rate of male victimization, and the factors that play a role in increasing risks. It's also important to see that maleness is only one facet of a complex set of identity factors that often create pressures and fears within males. I emphasize the importance of not allowing typical assumptions about masculinity to filter one's assumptions about a person. A trauma-informed approach to any work connected to victimization response demands that we approach everyone we meet with compassion and curiosity first, not a predetermined bias towards pathologizing and diagnosing.

Christopher M. Anderson

Author of *Trauma & PTSD in Male Survivors of Sexual Abuse Fact Sheet*

It is important to directly address economic issues in treatment. It is more difficult to treat the impacts of trauma and severe stress when people lack basic economic stability (e.g., secure housing, access to affordable health-care). Clinicians who work with traumatized populations should be familiar with social and community resources and support the people they treat in their efforts to access needed economic resources.

Bekh Bradley, PhD

Author of *Trauma and PTSD in Economically Disadvantaged Populations Fact Sheet*

### 4. What advice or suggestions would you give colleagues looking to integrate these resources into their practice?

Reviewing the materials and keeping them handy are good first steps. While these Factsheets are not recipe books on how to treat clients, they do highlight important areas to be aware of, including providing many additional resources that can be sought to gather further information. When working with clients who experience trauma, it may be useful to go back to these sheets and consider uses for application in your treatment planning. The section within the Fact Sheet titled "Unique Clinical Considerations (for Providers)" is particularly relevant for practitioners.

Jasmin Llamas, PhD

Author, *Trauma & PTSD in Ethnic Minorities Fact Sheet*

Get good consultation. Learn to mindfully and compassionately observe your own humanity and not use guilt or shame on yourself when you, as you inevitably will, act in a way that does not reflect cultural competence and cultural humility. Realize that culturally competent practice is a process, not something for which you can check a box as done.

Laura Brown, PhD

Author of *Cultural Competence in Trauma Psychology*

Get a firm rooting in the data on victimization. Understand that a profound percentage of the males you interact with (whether clinically or otherwise) are likely to be carrying within unspoken traumas that can negatively impact their health and wellbeing. Understanding that, ask how you can conduct your work in ways that make it more likely that a given male will feel encouraged and empowered to speak openly about their experiences with trauma. Find ways to make people feel safer.

Christopher M. Anderson

Author of *Trauma & PTSD in Male Survivors of Sexual Abuse Fact Sheet*



## Future Directions

As clinicians increase their understanding of cultural influences on the prevalence and impact of trauma, they should also work to integrate those understandings into their practice so that recovery from trauma is grounded within appropriate frameworks, guided by ethical principles, and geared toward better clinical work. This is an intentional and continuous process that is never fully complete; but when attended to, can result in clinicians integrating cultural competence in all aspects of their work. In addition to developing cultural competence at the clinician level, cultural competence at the institutional or systems level is also critically important.

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- Shavonne J. Moore, PhD**, is a licensed psychologist and health care provider in Boston, Massachusetts. She provides clinical services, supervision, and teaching at the Massachusetts Mental Health Center. Dr. Moore also develops trauma curriculum and trainings with the Trauma Center of the Justice Resource Institute (JRI). Her passion involves engagement through education and advocacy services geared toward ending sexual victimization. She has a strong commitment to working with marginalized and victimized populations and she engages in this work through multiple community avenues.
- Lesia M. Ruglass, PhD**, is a Licensed Clinical Psychologist and Assistant Professor in the Department of Psychology at the City College of New York, CUNY, where she also directs the OASAS certified Credentialed Alcoholism and Substance Abuse Counselor (CASAC) program. Dr. Ruglass also maintains a private practice in NYC. Her research and clinical interests center on integrated treatments for trauma, PTSD, and substance use disorders (SUD), with a focus on understanding and reducing racial/ethnic disparities in mental health and PTSD/SUD outcomes. She currently serves as Co-Chair of the Membership Committee.

## Invitation to Division 56 Fellows

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

# WEIRD Trauma Research: We Can Do Better

*Cathryn Richmond & Selamawit Hailu  
Virginia Commonwealth University*

Approximately 99% of all psychological research has been conducted by researchers at Western universities with 96% of samples from Western industrialized countries, though these countries represent only 12% of the world's population (Henrich, Heine, & Norenzayan, 2010). Not only does this lead to incorrect conclusions about the human species as a whole, but WEIRD (Western, Educated, Industrialized, Rich, Democratic; Henrich et al., 2010) methodology also dramatically limits our understanding of individuals within one's own society.

Such problematic methodology is particularly concerning in the context of trauma research. Minority status is crucial to consider, as discriminatory experiences can be traumatic and contribute to other adverse experiences (Clark, Anderson, Clark, & Williams, 1999; Williams, Connolly, Pepler, & Craig, 2005). The inextricable interlocking of power systems (e.g., race, class, sex, gender) and the influence of these systems on the experiences of minority groups is critically understudied (Cyrus, 2017; Ghabrial, 2017; Nettles & Balter, 2011), particularly in the context of traumatic or adverse experiences (Brown & Pantalone, 2011; Triffleman & Pole, 2010). Though a major shift in societal perceptions is warranted, the path begins with a better understanding of trauma within minority populations.

## Theoretical Basis of Trauma Research

The existing body of research on trauma experiences has been guided by theories such as Erikson's psychoanalytic theory of psychosocial development. However, this theoretical basis is inherently incomplete as the nature of development may differ by population, evidenced by the utilization of separate models of identity development for characteristics such as race (e.g., Cross, 1991; Helms, 1995).

With regard to race specifically, the majority of studies that include large samples of racial minority populations draw from urban areas in the United States (US). However, such environments are "highly 'unnatural' from the perspective of human evolutionary history," (Henrich et al., 2010, p. 7) such that attempts to generalize to an entire race from urban samples are inappropriate yet overwhelmingly common. Future research focusing on

more rural populations of racial minorities is needed, including consideration of races thought to be of minority status in the US as well as races considered to be of minority status in the population of interest.

## Trauma Methodology

The "home-field disadvantage" (Medin, Bennis, & Chandler, 2010) dramatically hinders the field as a whole. The nature of trauma research follows the assumption that certain events are unequivocally negative and represent a universal risk factor for impaired development. However, many events deemed by the researcher as "traumatic" may not be viewed as such by the participants, and vice versa. For example, many traumatic event checklists assess events such as parental divorce/separation (Bremner, Bermetten, & Mazure, 2000), negating that these events are culturally-specific rather than universal, both in occurrence and interpretation. Similarly, culturally-specific practices such as spanking or caning are typically assessed in the context of physical abuse, though they may only be viewed as abusive practices in certain populations (Lubell, Lofton, & Singer, 2008; Raval, Raval, Salvina, Wilson, & Writer, 2013).

Conversely, intrapersonal trauma, triggering of phobias, societal trauma, secondary/vicarious trauma, or in-group trauma are not typically assessed in the trauma literature. Furthermore, minority-specific events and factors influencing risk and resilience are rarely assessed. For example, factors such as age of migration and cultural be-

reavement for immigrants (e.g., Bhugra & Becker, 2005), asylum status and acculturative stress for refugees and asylum seekers (e.g., Li, 2016), living with family, age of coming out, and degree of outness for sexual minorities (Balsam et al., 2015), bathroom-related traumas and transition timing for gender minorities (Burnes, Dexter, Richmond, Singh, & Cherrington, 2016), and cultural identity including identity centrality, salience, culture of origin, and cultural practices and values (e.g., meditation/prayer, dignity, and two-spirit activities; Bhugra & Becker, 2005; Elm, Lewis, Walters, & Self, 2016; Umaña-Taylor et al., 2014) are also of critical importance yet rarely assessed.

## History and Heterogeneity

Perhaps one of the most restrictive aspects of research in minority populations relates to the field being historically bound. The current political climate in the US is



*Cathryn Richmond*



quite unique, particularly in the context of minority research. The Black Lives Matter and same-sex marriage movements have dramatically shifted the culture of the US and represent a unique period in our history. During segregation, studies on populations of African Americans were essentially non-existent, and the few that focused on such populations did so in a eugenics-based manner that pathologized cultural differences (e.g., Ellis, 1911; Koch & Simmons, 1926). Similarly, prior to the increased visibility of sexual and gender minorities, the only research involving these populations identified factors that differentiated them from the majority as innate and deficient. This characterization is further evidenced by titles such as “The Homosexual Problem” (Adler, 1917) and descriptions of homosexuality as “a sign of degeneracy” and “a sad, deplorable, pathological phenomenon” (Robinson, 1914).

Even recent research is overtly biased by stereotypes; the basis of most previous research is that minority status is a risk factor for atypical development. However, simply being a minority does not contribute to development of psychopathology. The systemic power structures contributing to negative societal perceptions of such minority groups and the resulting experiences of hate and discrimination facing these individuals represent the true risk.

These stereotypical views result in research that ignores within-group differences, treating heterogeneous groups as homogenous. The over categorization of racial groups assumes that these groups are homogeneous, that every individual will identify with at least one of these researcher-provided categorizations, and that individuals of “other” races will be both uncommon yet similar to one another. Furthermore, restricting participants’ identity selection to only a single race discounts the unique cultural influences experienced by multi-racial individuals. Moreover, with regard to ethnicity, the typical binary manner of assessment (Latinx or non-Latinx) is dramatically oversimplified, particularly given that many researchers as well as the US Census consider “Hispanic or Latino” to be a distinct and separate racial group.

Similarly, much research on sexual and gender minority populations assess these individuals as a homogeneous group and ignores biological sex via exclusion of individuals that identify as intersex. Although gender is distinct from sexual orientation and the experiences of sexual minorities are generally qualitatively different than those of gender minorities, results are often generalized to the entire LGBTQIA+ population (e.g., House, Van Horn, Coppeans, & Stepleman, 2011; Whitfield, Walls, Langenderfer-Magruder, & Clark, 2014).

## Future Directions

Though it may be difficult to conduct research without any aspects of WEIRD methodology, increasing awareness and disclosure of the ways in which one’s study might be affected by WEIRD biases would allow for more transparency and clarity throughout the field as a whole, strengthening the foundation of applications for practice. While it is standard practice to describe one’s sample, it is far less common for researchers to disclose their own sociodemographic variables and these variables potential influence on the research at hand. Burnes et al. (2016) provide one example of appropriately disclosing researcher characteristics that may influence their research perspective on the experiences of survivors of trauma that identify as transgender, as well as the impact of these characteristics on their methodology and interpretation of results.



*Selamawit Hailu*

In conclusion, participants should not be assumed to be homogenous regardless of minority status. Research that allows participants to identify as they

do in daily life rather than providing researcher-determined categories and that assesses within-group differences, both culturally and individually, is of critical importance. Rather than grouping individuals as “African Americans,” “Asian Americans,” or “Latinx/Hispanic,” researchers should instead avoid categorizing participants as such entirely if at all possible. If such grouping is deemed necessary for the research question, assessment of additional factors such as nationality, country of origin, generational status, language spoken at home, and religion is critical to the rejection of stereotypes. By doing so, researchers can identify the sources of patterns across race rather than concluding or asserting race as the pattern itself. Race and ethnicity should be assessed distinctly rather than as synonymous constructs. In addition, research on sexual and gender minorities should separately analyze the experiences of all combinations of sexual orientation and gender identity. The simple inclusion of individuals that identify as bisexual, asexual, or pansexual would strengthen the literature, as these individuals are typically excluded. Similarly, research in individuals identifying as trans\* should differentiate between male-to-female, female-to-male, non-binary, gender fluid, etc., as well as stage of transition for the two former identifications.

Furthermore, studies incorporating qualitative measures are essential to assess the factors deemed by the individual and their culture to be relevant. When a qualitative portion is not possible, a more comprehensive approach is crucial. In addition to “standard” (per US measures) events such as abuse and car accidents, items

related to individual and systemic discrimination and intrapersonal, secondary/vicarious, and in-group trauma should also be included. Future research also needs to incorporate assessment of resilience in addition to risk, including general protective factors (e.g., social support) as well as culturally- and individually-relevant factors (e.g., degree of outness, identity centrality and salience, the role of religion).

Finally, and what precedes the aforementioned suggestions, is awareness. The slang term “woke,” meaning raising an individual’s awareness of important issues, particularly those surrounding social justice, has recently gained popularity and entered into mainstream culture (Woke, Merriam-Webster, 2008). This term has been frequently used not only to signal one’s own awareness of the dominant paradigm but also to call on others to raise their attention (e.g., “stay woke”). Researchers studying trauma have a responsibility to “stay woke,” as characteristics of individual identity and society itself dramatically influence traumatic experiences. Thus, perhaps the most important direction to be taken as researchers is indeed to “stay woke,” as doing so naturally creates the space for critical perspectives that are necessary to judiciously evaluate research and limit the influences of WEIRD biases.

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**Cathryn Richmond** completed her Master’s degree in Psychological Sciences from James Madison University and is currently pursuing her doctorate in Developmental Psychology at Virginia Commonwealth University. She has training in a variety of disciplines including trauma research, clinical neuropsychology, assessment and measurement, and data management. Her current research interests broadly relate to risk in the context of resilience, particularly in regard to stressful experiences and coping



*with traumatic stress, and she is committed to expanding culturally sensitive research in underserved populations experiencing marginalization and oppression including examination of the way in which the intersectionality of power structures influence resilience.*

**Selamawit Hailu** received her bachelor's degree in psychology and cognitive science from the University of Virginia and is currently a Clinical Psychology gradu-

*ate student at Virginia Commonwealth University. Her research interests broadly include ethnic-racial identity development, cultural adaptations of evidence-based interventions for youth anxiety, depression, and trauma, and the dissemination and implementation of evidence-based interventions. Aside from her research interests, she has training in racial reconciliation, behavioral health within integrated primary care settings, and restorative justice practices.*

## New Fellow: Regina (Gina) McGlinchey

NEW FELLOW

**R**egina (Gina) McGlinchey is a Supervisory Research Scientist at the VA Boston Healthcare System and Associate Professor of Psychology in the Department of Psychiatry at Harvard Medical School. Since receiving her PhD in Experimental Psychology from Tufts University, she has been conducting clinical neuropsychological and neuroscience research on cognitive and neural changes associated with aging, stroke, disease, alcoholism, and, over the last decade, military-related brain and psychological trauma. Some of her most important contributions to science have come from her role as Principle Investigator and Director of the VA Rehabilitation Research and Development National Network Center for Traumatic Brain Injury called the "Translational Research Center for TBI and Stress Disorders" (TRACTS). Together with a team of researchers at TRACTS, she is conducting multidisciplinary, clinical research aimed at providing a multimodal characterization of mild traumatic brain injury, and in understanding how associated stress disorders, including PTSD, influence how brain injury is expressed at the psychological, biological and neurobiological levels.



*Regina (Gina) McGlinchey*

It is her hope to use this understanding to create effective treatment opportunities for post 9/11 Veterans who often suffer from multiple, co-occurring psychological and physical conditions.

Gina's advice to new trauma psychologists is to try to approach each individual patient/study participant with a sense of professional empathy and to try to understand their lifetime history of exposure to physical and psychological trauma. This will help to put the present circumstances into a lifetime biological/psychological context that is specific to that individual.

When not at her "real" job, Gina works with her husband operating an apple orchard that keeps her busy outside year round. The work includes pruning the fruit trees in the winter months, maintaining the property throughout the year, and running a retail and pick-your-own apple business in the fall. While the business is a lot of physical work, she finds it highly rewarding and a complete escape from the pressures and challenges of life as a neuroscience researcher.

# Who's Who: Robyn Gobin, PhD

## 1) What is your current occupation?

I am a Licensed Clinical Psychologist and an Assistant Professor in the Department of Kinesiology and Community Health at the University of Illinois at Urbana Champaign. I maintain a small trauma-focused private practice where I use research supported therapeutic approaches.

## 2) Where were you educated?

I received my PhD in Clinical Psychology from the University of Oregon.

## 3) Why did you choose this field?

I am passionate about using my knowledge and experiences to help others experience more vitality and realize their full potential.

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

The privilege of walking alongside courageous survivors during their recovery is the most rewarding aspect of my clinical work. I love helping my clients to discover strengths and abilities they never knew they had. The most rewarding aspect of my research is knowing that it will play a role in supporting trauma survivors' recovery.

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

The lag time between conducting research and disseminating it to the public so that it can actually impact people's lives.

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

I create boundaries between my personal and professional lives. I am intentional about taking the time to laugh, play, and feed all parts of me. There is more to me than being a psychologist. A consistent self-care regimen and mindfulness meditation have played huge roles in bringing balance to my life.

## 7) What are your future plans?

I plan to explore how I can use technology and social media as a vehicle for giving psychology away. APA

President Jessica Henderson Daniel's Citizen Psychologist initiative resonates with me. I want to be a part of this movement by applying psychological science to address mental health issues that threaten well-being in the communities I belong to.



*Robyn Gobin, PhD*

## Social Media News

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



# Division 56 Member News

Compiled by Ilene Serlin, PhD

**Kalayjian, EdD** conducted an all-day workshop on Integrative Healing and Self Care in NYC on September 30th, and gave a lecture October 2nd to Solebury School Community on transforming aggression and bullying, shared hands-on tools for EQ, empowerment, emotional management and Soul-Surfing. On October 10th, she was interviewed by Jim Masters on [CUTV.com](http://CUTV.com) on the topics of EQ, transforming trauma into healing through resilience, forgiveness, and meaning-making. Here is the link:

<http://www.blogtalkradio.com/cutvnewsradio/2017/10/10/cutv-news-radio-spotlights-dr-ani-kalayjian-of-meaningful-world>

She spoke at the Unification Theological Seminary on “Forgiveness & Reconciliation: Post Trauma Healing and Meaning-Making.” On October 26th, she chaired a symposium at the UN, *Educating our Youth: Nurturing Conscientious Leaders*. On the same date, she chaired the United Nations Day, Photo Exhibit of Humanitarian Relief “Transforming Suffering into Resilience” at the United Nations Headquarters, and on October 28th she conducted an all-day workshop on Post Disaster Healing, Outreach, Soul-Surfing, and Meaning-making.

**Nancy Sidun, PhD** co-edited “A Feminist Perspective on Human Trafficking of Women and Girls: Characteristics, Commonalities and Complexities.” It is published by Routledge, ISBN 13: 978-1-138-70175-5.

**William Foreman, PhD**, was given the Distinguished Medal for his work in the prison in 2014. He notes the work is truly praiseworthy. But only because of the commitment and desire of the patients to know themselves better. The group therapy is 28 sessions long complete with a 70-page workbook. The intended patient is a career criminal who began deviating from the social norms by 5th grade, certainly before middle school, often by 3rd grade. I never expected such interest from people in prison. The waiting grows and grows by self-referral. The truth is most of the participants suffer Complex PTSD. The program formed phenomenologically by what the men informed me as to what they needed to delve into. The program fits well within the recent work with Complex PTSD. The men’s faces mature, which seems an odd marker for effectiveness. The prison yard operates at about the maturity of middle school, and through the course of therapy the participants mature and became immune to the dictates of other inmates. The men’s behavior changes for the better, so noticeably that the custody officers are very supportive of the group.

**Michael Eigen, PhD** spoke for the N.J. Institute for Training in Psychoanalysis at Montclair State Teachers

College on October 29th. A new Karnacology article is online: <https://karnacology.com/2017/06/20/the-therapy-womb-by-michael-eigen>

Brent Potter and others added quotes and photos to the Living Moments site related to Mike’s work: <https://m.facebook.com/HonoringMichaelEigen>

**Robyn E. Brickel, MA, LMFT** is the director and lead therapist at Brickel and Associates, LLC, a private practice in Old Town Alexandria, Virginia, which she founded in 1999. She is deeply committed to clinical practice, professional education and better public awareness of mental health issues (see the full list of Robyn’s trainings and post graduate certifications at [www.brickelandassociates.com](http://www.brickelandassociates.com)). Robyn practices a strengths-based, trauma informed, and systemic approach to therapy and consultation. She helps clients process and overcome trauma, addictions, challenged family systems, and mood disorders including maternal mental health issues. She works with individuals (both adolescents and adults), couples, families, and groups. She provides clinical consultation to other therapists, is a workshop presenter and speaks to school and parent groups about mental health risks facing people today. Robyn also volunteers as a mental health consultant to a local non-profit organization to raise awareness of the mental health effects of Domestic Violence on two forensic topics:

1. Is Parental Alienation a Legally Trustworthy Explanation of Child Sexual Abuse Allegations in Divorce Cases? The Contributions of Clinical and Scientific Knowledge
2. Do DSM-5 PTSD Categorical Criteria Identify C-PTSD?

**Ilene Serlin, PhD, BC-DMT**, co-wrote a chapter in the *Oxford Handbook of Dance and Wellbeing*. The official launch of the book will be on February 23, 2018, at Edge Hill University, UK:

Serlin, I. A., Golduv, N., & Hansen, E. (2017). Dance movement therapy and breast cancer care: A well-being approach. (In Karkou, V., Oliver, S., & Lykouris, S., Eds.) *Oxford handbook of dance and well-being*. London: Oxford University Press.

Available: <https://global.oup.com/academic/product/the-oxford-handbook-of-dance-and-wellbeing-9780199949298?cc=us&lang=en&>

Link to chapter: [http://www.union-street-health-associates.com/articles/dance\\_movement\\_therapy\\_and\\_breast\\_cancer\\_care.chapter.pdf](http://www.union-street-health-associates.com/articles/dance_movement_therapy_and_breast_cancer_care.chapter.pdf)

## Jana Rivers-Norton, PhD

The AZ-Humanities Organization sponsored a book reading as a part of their AZ Author + Talk Program last June. They featured the fourth chapter on Edith Wharton entitled “When Words First Spoke” from *The Demeter-Persephone Myth as Writing Ritual in the Lives of Literary Women*, recently published by CSP in Dec 2016/Jan 2017.

Her latest book proposal for *Transcending the Tragedy of*

*Medea in Life, Love, and the Literary Arts*, was recently accepted for publication by Cambridge Scholars Publishing, slated for a May 2019 release. In addition to telling the life stories of the literary women Hilda Doolittle, Louise Bogan, Doris Lessing, Ellen Glasgow, Edna St. Vincent Millay, and Charlotte Perkins Gilman, it tells her own personal story about healing mother-daughter relationships (now touched by Alzheimer’s) through autobiographical storytelling as the discovery of self-identity, especially in families where unresolved intergenerational trauma is prevalent.

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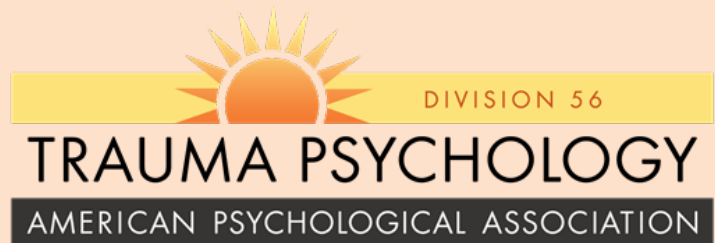
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| <u>Issue</u> | <u>Submission Deadline</u> | <u>Publication Date</u> |
|--------------|----------------------------|-------------------------|
| Spring       | February 1                 | April                   |
| Summer       | June 1                     | July                    |
| Fall         | October 1                  | November                |

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