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DIVISION 56

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

NEWS

Presidential Voice

Sylvia Marotta-Walters, Ph.D.

The 2019 APA Convention was a huge success for Division 56, a success that was shared with non-participants through the efforts of our program chair Delishia Pittman and our social media chair Bryann DeBeer. Through Facebook and Twitter posts during the convention, participants could access the excellent content of our poster sessions, symposia, and discussions in Chicago and elsewhere around the country.

The Presidential Symposium on psychotherapy outcomes covered topics such as how one defines symptom reduction and developmental repair among adult and child clients, and how functional improvement plays out concurrently and separately in the course of a therapy trajectory. A big thank you goes to the panel participants, Terry Keane, Laura Brown, Anthony Mannarino, and Michelle Bovin for sharing their expertise with a full meeting room of participants at the convention center.

The hospitality suite was also put to good use, thanks to the work of Lynsey Miron and Susan Hannan. It was especially gratifying to see how many students and early career psychologists came for networking, mentoring, and socializing with division leaders and members.

Sylvia Marrotta-Walters

As the call for next year's convention is open now, I encourage all of you to consider submitting a proposal. The 2020 theme for President-elect Allard's convention is "Advancing Trauma Research, Practice and Policy through Reciprocal Collaborations."

Every year Division 56 recognizes significant contributions to the field of Trauma Psychology through its award ceremony and social hour. This year's awards are:

Dissertation Award: Viann Nguyen Feng "A randomized controlled trial of a mobile ecological momentary stress management intervention for students with and without a history of emotional abuse."

American Psychological Foundation Award for Trauma Psychology: Kit Elam, PhD. "Culturally sensitive trauma informed care: Learning from Latino families."

Outstanding Contribution to Trauma by Early Career Psychologist Award: Alyson K. Zalta, PhD. Her research program addresses ways to alleviate the mental health burden of trauma through enhancing resilience factors.

Early Career Award for Racial/ Ethnic Minority Psychologist in Trauma Psychology: Delishia Pittman, PhD. Her research centers on racial and ethnic disparities in health behaviors and outcomes, including substance use, coping, and the stress continuum among African Americans.

Award for Outstanding Service to the Field of Trauma Psychology: Phyllis Cohen, PhD. Her career involves a lifelong focus on helping diverse and disenfranchised individuals through pro bono

community intervention programs.

Award for Outstanding Contribution to the Practice of Trauma Psychology: Lillian Comas-Diaz, PhD. As private practitioner in the Washington DC area, her career focus is on ethnocultural approaches to mental health, intersecting identities, social justice, and international psychology.

Award for Outstanding Contribution to the Science of Trauma Psychology: Bethany Brand, PhD. As the principal investigator of a longitudinal international treatment outcome study of dissociative disorders, Dr. Brand contributes to the literature on distinguishing dissociative conditions from other mental disorders, and on the use of psychological tests to accurately classify dissociative spectrum disorders.

Award for Outstanding Contributions to Trauma Psychology: Kathleen Kendall-Tackett, PhD. Dr. Kendall-Tackett is a prolific writer, having authored more than 450 articles, or chapters, is the senior editor for the division's journal, and has authored or edited 38 books. Her two main areas of study are family violence and perinatal health. Her work on the long term health effects of childhood abuse is interdisciplinary and reaches both professional and popular audiences.

The Division's Lifetime Achievement Award: Laurie Ann Pearlman, PhD. Dr. Pearlman engages in research, service delivery, training, and education. Her theoretical framework, the constructivist self-development theory is a way of understanding the intersections of human development, attachment, and trauma. Internationally, Dr. Pearlman has spent decades working at the societal level with trauma victims in Rwanda and the Congo.

We awarded two media awards this year: An external award for Outstanding Media Contributions: Maria Sacchetti, Washington Post, who provides a voice for diverse individuals exposed to trauma, including immigrants and disaster survivors. Our internal award for Outstanding Media Contributions: Bryann DeBeer, PhD, for chairing our Social Media Committee and ensuring that trauma psychology stays in the forefront of our members thoughts throughout the year.

As the fall semester unfolds, the division continues to be actively involved in inter-organizational projects. President Julian Ford of the International Society for Traumatic Stress Studies and I are in conversations about involving pediatric and family medicine, health education, and legal/forensic professionals in a coalition to address child maltreatment and child welfare. The task force on moving the trauma competencies to subspecialty status continues its work, meeting during the convention with APA staff Catherine Grus and Toni Minnitti from the Education Directorate. I hope to have an initial framework for the division to consider at the mid-year meeting.

Our new Division Fellows Chair, Priscilla Dass-Brailsford, is encouraging all Division 56 members to consider applying for Fellow status. Details can be found on both the Division and APA websites.

Happy Fall everyone!
Sylvia

AWARDS

Division 56 Honored as Major APF Contributor

Division 56 was among the awardees recognized by the American Psychological Foundation (APF) at their annual soirée during the 2019 APA Convention in Chicago. Division 56 was honored as a major contributor with its award. The division's donations benefit the overall goals of APF and Division 56 with an annual research grant awarded to upcoming researchers.

At right: Diane T. Castillo, PhD, Division 56 Past President, holds the award, and a picture of the award itself.

Jonathan Cleveland, PhD
Editor-in-Chief

Editor's Note

Greetings and welcome to the fall issue of *TPN,*

Over the past few months, we received many excellent submissions. So many, in fact, that some will need to be included in the spring issue. In the pages that follow, you will find a wonderful variety of articles, essays, poems, session excerpts, and announcements. Please see below for full details. Be sure to visit this month's Who's Who section to learn about recent recipient of the Division 56 Dissertation Award, and outgoing *TPN* student section advisory editor, Dr. Viann Nguyen-Feng

We hope you consider submitting your work for inclusion in our spring issue. Please note, the submission deadline is March 2nd.

Best,
Jon

Jonathan M. Cleveland, Ph.D.
Editor-in-Chief

IN THIS ISSUE

Letters to the Editor

To Whom it May Concern:

It was a Thursday. My professor gave each of the students a copy of an e-mail we had received earlier that day. He asked if we knew what receivership was; I did not. I had no idea walking into class that this receivership was about to change the trajectory of thousands of students' lives, including mine.

Everyone told us it would be fine. We were the only Clinical Psychology program in the state and there was no way that this program would shut down. I heard the phrase "cautiously optimistic" so many times that I still cringe when those two seemingly insignificant words are put together.

School closed on a Friday. Thousands of students, including myself, were traumatized. My dream of being a Psychologist came to an abrupt halt and my education had taken a detour by no fault of my own. Argosy University robbed me of my stipend, my credit score, and at times, my mental health. It did not, though, strip me of my dream.

It is incredibly lonely to be going through this process. Few have experienced an abrupt closure of a University that has been around for decades. How does one grieve a dream deferred? Or hope that was consistently crushed those grueling months?

Argosy University took many things from me, but it did not steal my passion to help others, it just created an obstacle in getting there.

Sincerely,
A Determined Former Student

To the Editor,

Immigrants—regardless of their nationality or citizenship status—are victims of on-going trauma. Politicians, law enforcement, and news agencies have constantly directed their attention to the legal status of this population. Nevertheless, mental health care providers should be informed and address the issues that may impact the psychological health of this vulnerable population.

Most immigrants have experienced great trauma prior to their migration. At home, they have suffered extreme circumstances that have led them to their decision to migrate to other countries. Some of these include extreme poverty, gang-related persecutions, and high-risk environments which endanger their lives and expose them to abuse. These traumas lead to their perilous journey. However, as immigrants begin their pilgrimage to different countries, they face different challenges, such as food scarcity and highly infectious environments. Along the different phases of these journeys, immigrants continue to be exposed to abuse—particularly from those who promise to help them with their journey—as well as remaining vulnerable to extreme feelings of isolation and abandonment. Lastly, when society at large holds negative perceptions regarding this population, immigrants become victims of discrimination.

It is of great importance for mental health care providers to help establish our society's understanding that these individuals are also human beings with dignity. Trauma has been and will continue to affect them greatly, as it is a universal experience not dictated by race, culture, or nationality.

Sincerely,
Rita Michelle Rivera
Doctoral Student

Division 56 Listservs

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

div56@lists.apa.org	*for discussion among members*
div56childtrauma@lists.apa.org	*for child trauma topics*
div56dissociation@lists.apa.org	*for post-traumatic dissociative mechanisms development*
div56ecpn@lists.apa.org	*for early career psychologists networking*
div56stu@lists.apa.org	*for student forum*

LGBTQ+ Sexual Trauma Survivors: Motivational Interviewing as an Approach to Clinical Work

Amy E. Ellis, Ph.D. & Joan M. Cook, Ph.D.

Sexual and gender minorities (SGM) encompass members of the LGBTQ+ community as well as any individuals whose sexual orientation, gender identity, and reproductive development is considered to be outside physio-socio-cultural norms (NIH, 2019). SGM individuals are a population that is disproportionately affected by trauma, more specifically hate violence (acts of discrimination or violence based on gender, sexual orientation, race, etc.), intimate partner violence (IPV), and sexual assault.

Amy E. Ellis

A 2019 report by the Office for Victims of Crime found that bisexual men and women report more instances of IPV than do heterosexual and gay/lesbian individuals. Staggeringly, the lifetime prevalence of IPV for transgender individuals ranges somewhere between 24-47%. Rape and sexual assault also occur at higher rates for SGM individuals. Notably, 40% of gay men and 47% of bisexual men report sexual violence, as compared to 21% of heterosexual men. Trans individuals and bisexual women face the most alarming rates of sexual violence. Among both of these populations, sexual violence begins early, often during childhood (Human Rights Campaign, n.d.). A startling high percentage of transgender people, that is 47%, are sexually assaulted at some point across their lifespan (National Center for Transgender Equality, 2015).

Joan M. Cook

Beyond these direct and overt forms of trauma, SGM individuals are disproportionately exposed to day-to-day discrimination, peer and parental rejection, unsupportive or hostile work or social environments, and unequal access to opportunities afforded to heterosexuals, including marriage, adoption and employment non-discrimination (Balsam, Rothblum, & Beauchaine, 2005). Chronic expectations of rejection, internalized homophobia, alienation, and lack of integration with the community can understandably lead to problems with self-acceptance (Hatzenbuehler, 2009; Meyer, 2003). As a result, SGM male-identifying individuals are significantly more likely than heterosexual males to report experiencing mental health problems, like depression and anxiety, as well as several behavioral health risks, such as alcohol use and sex-risk behavior (Hequembourg, Bimbi, & Parsons, 2011).

SGM male-identifying sexual abuse survivors have unique health care needs that require a trauma-informed approach. Such an approach would integrate gender- and SGM-based principles, alongside a comprehensive understanding of the adverse consequences of trauma on emotional, and physical well-being. Hopton and Huta (2013) evaluated the treatment effects of a male-centered curriculum focused on gender role issues and abuse. Of the 114 men who received the treatment, there was overall improvement in depression and PTSD symptoms. The authors of this important study called for future research and programming to address treatment ambivalence in this population, promoting in particular the use of Motivational Interviewing (MI; Miller & Rollnick, 2013).

MI could help in assisting SGM men to reduce ambivalence around emotional and behavioral challenges, and to enter mental health treatment. MI is an evidence-based, patient-centered approach that explores and develops patients' motivation and commitment to change within a collaborative, highly empathic patient-clinician relationship. Clinicians blend a combination of fundamental patient-centered counseling techniques (e.g., reflective listening) with advanced strategic methods (e.g., developing discrepancies between important life goals and current behavior) to elicit patient statements that favor change, called "change talk," and diminish those that argue against change, called "sustain talk."

Peer-based support might be another way of reducing ambivalence towards mental health support. The use of mutual self-help groups (e.g., 12-step groups) have been widespread for many years. Peer specialists, individuals who identify as members of the community and have a shared connection, are those individuals who are recruited and trained to deliver

psychological treatments and act as paraprofessionals, Research indicates the utilization of peer specialists in formally delivering mental health interventions within service systems can improve client engagement in treatment (Davidson, Bellamy, Guy, & Miller, 2013) along with numerous other advantageous outcomes, such as increased feelings of acceptance by others and decreased stigma (Repper & Carter, 2011). While there is a great increase in the use and role of peer specialists in delivering mental health interventions, it is still not standard treatment for trauma-related disorders. There is some work showing that peer support can also facilitate positive outcomes for trauma-specific evidence-based treatment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).

Applying MI When Working with SGM Trauma-Survivor Clients

Miller and Rollnick (2013, p. 29), define MI as "a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."

MI actively works against a hierarchical relationship and power imbalances. More specifically, it means asking open-ended questions that are free of bias or microaggressions. For example, "What has your transition been like?" as compared to a question with biased judgment, "Your transition must have been hard especially since you're a daycare provider working with young children, no?" The latter connotes a judgment that it is less acceptable for daycare providers to transition, as well as implies that he might be part of the vampire myth and likely to abuse the children he is caring for, although that may not be the clinician's intent. Asking open-ended questions that allow for the client to fill in their experiences is paramount to building a collaborative relationship. Affirming the person's positive aspects and the full intersectionality of their many identities is essential to helping the client feel seen, understand, and cared for in the therapy room. Statements like, "As a parent, you're working hard to protect your children from being bullied" are more affirming than "As a lesbian, you're working hard to protect your children from being bullied".

Additionally, MI focuses on the client's motivations, which also means clients define their problems, issues, or difficulties without the judgment from a practitioner. Therapists can be mindful to not superimpose their own belief system on clients, focusing on open-ended questions of "what brings you here today?" versus something akin to "you noted that you were gay on the intake form, is that what brings you to therapy?" The former question allows for the client to share the intersectionality of their identities in a way that is self-defined, initiated, and expressed.

MI is also a strengths-based perspective that focuses on empowerment and resiliency. Practitioners employing this style reflects back what clients are doing, have done successfully, and what clients believe they are capable of accomplishing, rather than focusing on what they have not yet done, have been unsuccessful in doing, or believe they cannot accomplish. Further, the model emphasizes core strengths and values inherent in the person, rather than deficits. This is particularly important from an affirmative care standpoint, focusing on resiliency in the face of SGM minority stress, lack of access to and inadequate resources, and stigmatization/discrimination.

Moving Forward: A Community-Based Partnership

Given what we know about the need for trauma-specific, gender-based services for SGM male-identifying individuals, and the power of MI and peer-delivered services, we have partnered with MaleSurvivor, a non-profit organization that is focused on helping men with sexual abuse/assault histories heal, to refine MI to meet the unique needs of this population.

We are conducting a randomized controlled trial comparing two versions of MI to enhance treatment engagement, and reduce depression and anxiety, in SGM male-identifying sexual abuse survivors. Groups are 1.5 hours, meet for 6 consecutive weeks, and are facilitated by 20 peer leaders who were extensively trained in peer-based work, trauma-informed principles, and MI.

To read more about this innovative study please see https://peersformenshealthstudy.com

Given the prevalence of sexual trauma in the lives of men and more specifically sexual and gender minority male-identifying individuals, and its well-documented connection to mental and physical health disorders, facilitating their entry into formal mental health services is imperative. Because of the high level of poly-victimization among male survivor populations, this research is also expected to generate insights generalizable across multiple forms of trauma. In addition, given the significant increase in risk for many medical and psychiatric diagnoses for trauma survivors, this research has potential to improve understanding of barriers to trauma survivor engagement across all areas of heath care. Information garnered may also help underscore additional innovative targets for preventive interventions directed at further reducing health disparities in SGM populations.

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Dr. Joan Cook is a clinical psychologist and Associate Professor in the Yale School of Medicine, Department of Psychiatry. She has over 150 scientific publications in the areas of traumatic stress, geriatric mental health and implementation science fields. Dr. Cook has worked clinically with a range of trauma survivors, including combat veterans and former prisoners of war, men and women who have been physically and sexually assaulted in childhood and adulthood, and survivors of the 2001 terrorist attack on the former World Trade Center. She has served as the principal investigator on seven federally funded grants, was a member of the American Psychological Association (APA) Guideline Development Panel for the Treatment of PTSD and was the 2016 President of APA's Division of Trauma Psychology. Since October 2015, she has published over 80 op-eds in places like CNN, TIME Ideas, The Washington Post and The Hill.

Dr. Amy Ellis is a licensed clinical psychologist and the Assistant Director of the Trauma Resolution and Integration Program (TRIP) at Nova Southeastern University. TRIP is a university-based community mental health center that provides specialized psychological services to individuals age 18 and above who have been exposed to a traumatic situation and are currently experiencing problems in functioning as a result of the traumatic experience. Dr. Ellis has also developed specific clinical programming focusing on trauma-informed affirmative care for sexual and gender minorities as well as gender-based services focusing on male-identifying individuals at TRIP. Dr. Ellis is involved in a variety of leadership activities within the American Psychological Association (APA), including service as a Consulting Editor for three peer-reviewed journals, and Guest Editor for Practice Innovations on a special issue dedicated to the role of evidence-based relationship variables in working with sexual and gender minorities. She is also the Editor for APA's Division 29 (Psychotherapy) website.

Is There Room for Trauma Work in Inpatient Care: The Perspective of an Acute-Care Psychologist

Madeline McGee, Ph.D

In recent years, there has been a proliferation of attention paid to trauma-informed care. It is not surprising then, at least for our area of New York, that I "grew up" in professional families in which trauma work was spotlighted. I was an extern at a residential facility that had a trauma-sensitive milieu, earned an internship at a hospital with a dedicated trauma track, and currently work under the leadership of a child psychologist who is the recipient of a Category II NCTSN grant. Often, psychology trainees rotate onto the short-term adolescent inpatient unit where I work gung-ho to use their newly learned trauma education and skills on their adolescent inpatient cases.

Madeline McGee

It is in this context that I frequently consider how we can increase trauma-informed care in this setting. This is with good cause as numerous studies have documented the high percentage of adolescent inpatients that present with exposure to potentially traumatic events (e.g., Havens et al., 2012; Lipschitz, Winegar, Hartnick, Foote, & Southwick, 1999; Weine, Becker, Levy, Edell, & McGlashan, 1997), as well as those that meet actual or likely criteria for a Posttraumatic Stress Disorder (PTSD) diagnosis (Koltek, Wilkes, & Atkinson, 1998; Havens et al., 2012). In fact, we have had numerous patients present to the unit feeling as though their trauma history is at the core of their symptom profile and to not address it is incredibly invalidating. As many trauma treatments require a narrative and all are based on the foundation of a stable therapeutic relationship, a short-term inpatient unit is not the ideal place for this work, so we initially focused our attention on a specialized group therapy program for survivors of various forms of trauma based on the SPARCS protocol (DeRosa et al., 2006). Our experience was that, despite creative problem-solving around how to market and engage patients in the group, it was poorly attended. When we did have regular participants, the patients repeatedly found trauma-specific psychoeducation to be activating as they did not anticipate doing this kind of work during their hospitalization. When we pulled trauma-specific content, we were left with a generic skills group. Despite valiant efforts, we were left resigned: *To continue to use our trauma expertise in this setting just causes us more frustration. I guess this just isn't the place to do trauma work.* Or is it?

Focusing on the fact that we "can't do trauma work" in an acute-care hospital was not helpful to our patients or ourselves as staff. While they are multiple models of trauma-informed care that apply to systems (Attachment, Self-Regulation and Competence [ARC] model, Blaustein & Kinniburgh, 2018; Sanctuary Model, Bloom, 2010), there does not appear to be a well-articulated resource for how cases of adolescents with a trauma history are "handled" on an inpatient unit. The following paragraphs represent an effort to articulate what we are doing that seems to be working well and the hope that sharing it provides guidance for others.

Fostering a Trauma-Sensitive Unit

Promote Safety

Psychological safety is promoted in a number of ways. One component includes the use of safe language. We frequently found that patients introducing themselves during our morning Community Meeting or discussing their history in group therapy would use explicit language to describe their maladaptive behaviors. Frequently hearing peers talk about behaviors such as suicide attempts, substance use and purging only seemed to reinforce, and potentially glorify, such behaviors, while possibly triggering some patients. As such, we have adopted the term "MUPs" from the SPARCS manual (DeRosa et al., 2006). MUPs, or Mess-You-Ups, refer to behaviors that seem to be effective in the moment to reduce emotional or behavioral dysregulation but cause additional difficulties later on. We have been effective in promoting a culture shift in which patients announce "I came in for a MUP" or tell a staff member "I MUP-ed" when discussing these behaviors within the community, and reserve a more nuanced discussion for more private patient-staff conversation. A second component relates to unit rules explicitly prohibiting any form of "PC" (peer contact) including hugs and high-fives. Many patients complain about the unfairness of this rule as they wish to express themselves physically after establishing close peer relationships during this sensitive time in their lives (e.g. hugging a discharging patient). However, most patients are able to understand the rationale behind

the rule when reminded about the fact that many people are not comfortable with touch (experiencing or witnessing it) based on their prior experiences. Patients are encouraged to find alternate ways of expression (e.g., air-hugs, using their words, making bracelets for each other during an art group). Psychological safety is also promoted through a tight unit structure that blends therapeutic activities, school, leisure activities and family visiting with time for meals and hygiene. Once patients leave their rooms in the morning, their doors are locked and they are expected to follow the day's programming. Many patients have complained that they prefer other local hospitals where they can "hang out" and "be left alone;" however, our experience has been that structure promotes predictability and safety, and serves as behavioral activation for our patients.

Physical safety is promoted in a number of ways. The most salient ones related to establishing a trauma-sensitive unit involve the use of Coping Cards, behavior plans and coaching to decrease unsafe behaviors and reduce the use of restraints or other physical interventions. Coping Cards are a fancy name for index cards on which patients write their go-to coping skills on admission and add additional skills as they learn them in individual and group therapy. Having the skills written down provides a concrete reminder when they are too dysregulated to think straight and also allows all staff (not just the primary therapist) to intervene effectively. Similarly, coaching refers to attempts to verbally de-escalate patients and avoid use of physical interventions. Since the implementation of our DBT program, all staff on our 24/7 shifts combine validation, problem-solving and skills training along with verbal de-escalation. Finally, specialized behavior plans are frequently used with patients who require increased reinforcement to display more adaptive behaviors. These combined efforts, in addition to hopefully reducing restraint use and the loss of control experienced by patients during physical interventions, also serve to help patients establish a greater sense of self-efficacy in maintaining safety.

Focus on Staff Awareness and Support
Working in a fast-paced setting with youth all presenting with safety concerns is tough on a regular day. In the extreme, such work can contribute to secondary traumatic stress or more generalized burnout. As such, we take care to promote trauma awareness and resiliency in our colleagues. As staff, we consider the relation between trauma and maladaptive behavior, as well as the effect of pejorative language (e.g., "manipulative") on our ability to optimally work with our patients. Staff members from all disciplines, including front-line staff, are encouraged to join our daily Team Meetings so they can have greater insight into the potential reasons for a youth's particular behaviors, triggers and more appropriate ways to work with him/her. We encourage impromptu huddles of the primary team when facing a challenging issue (e.g., should a youth have fewer consequences for a maladaptive behavior if it was partially influenced by the youth's trauma history). This promotes shared responsibility for the decision-making and ensures that no one who is either too stringent or too lenient makes the majority of decisions on the case. We make special effort to coordinate care with the on-site school teachers as behavioral difficulties frequently play out in that setting and it is important to ensure that teachers are providing coordinated care. Finally, we support each other through debriefs after critical incidents, light-hearted lunches and festive parties when there is good news to celebrate. Never underestimate the power of mindful eating!!

Working with Individual Patients

Conceptualize Your Work as Beginning Trauma Treatment
Frequently, we felt as though we were avoiding trauma work. We repeatedly told the same patients who were readmitted over and over that they could "do the trauma work" when they stabilized with a longer-term outpatient provider. However, we realized that we were essentially saying that they may have to wait to do the narrative component elsewhere. Often in individual therapy, we were hitting on the core components of early trauma work: engagement, psychoeducation about trauma and its sequelae, and skill-building. Having a rich milieu, an interdisciplinary treatment team and time to observe patients also allows us to put on our "detective hats" and refine hypotheses about how trauma is at play. As passionate advocates for trauma-informed care, telling ourselves that there was no room for trauma work at our level of care was incredibly frustrating, and modifying this cognition allowed us to focus on what we could do here and do it well.

Know When to Dive In
At times, we do have patients for whom it seems appropriate to embark on a narrative component of treatment. Patients who met this criteria typically were: 1) known to our team based upon multiple prior admissions; 2) had traumatic stress symptoms that seemed to be underlying their current difficulties in functioning; 3) were stable with respect to safety concerns; and 4) would be staying on the unit a few weeks, typically while awaiting a next placement. For example, one patient was seen during her 5th admission in 6 months and it was clear that trauma-related symptoms related to a history of chronic sexual abuse were impacting her emotion regulation and ability to maintain safety. Anecdotally, it seems that completing a trauma narrative helped modify troublesome cognitions (e.g., "it was my fault") and emotions (e.g., shame), and also helped her make meaning from that difficult experience.

Plan for Future Success
All our patients are assisted in creating personalized coping plans to help them anticipate how they will

handle likely triggers they may experience post-discharge. For patients with a trauma history, their coping plans may be further personalized to include traumatic stress symptoms as well as trauma reminders, as well as more generic environmental stressors. These are reviewed in a safety planning session with the patient's family. Care is taken to provide appropriate referrals for these patients, sometimes for trauma-specific care and other times for care targeting more acute symptoms, such as chronic suicidality or active substance use disorders. We also formulate discharge plans incorporating educational, in-home and child protective services providers where appropriate. A final component of our efforts to plan for future success involves educating professionals involved with the patient and family. We frequently see professionals who impress as well-intentioned but whose efforts are invalidating or detrimental. For example, some local schools tend to recommend home instruction to remove a youth from a school environment with bullying, which may serve to re-victimize the victim. We've also had numerous experiences with law enforcement personnel who pressure families and patients to discontinue their efforts to pursue legal measures against alleged perpetrators because they believe the patient will not be able to withstand the pressure of legal proceedings. Although both of these circumstances may be appropriate in some cases, our expertise in trauma allows us to potentially reshape these professionals' preconceived notions and help patients/families weigh pros and cons of various courses of action.

Theodore Roosevelt once said "Far and away, the best prize that life offers is the chance to work hard at work worth doing." Trauma work is hard and worth doing. I'm grateful as an inpatient psychologist to have the chance to be part of this prizewinners' circle.

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Supervision in a Veterans Health Administration Outpatient PTSD Clinic: Reflections on Beneficial Practices for Psychology Trainees

John Correa, Ph.D. & Jessica Tripp, Ph.D.
VA San Diego Healthcare System

A growing number of veterans are accessing treatment for posttraumatic stress disorder (PTSD) through the Veterans Health Administration (VHA) and the U.S. Department of Veterans Affairs (VA). In 2015, over 568,000 veterans received treatment for PTSD from the VHA system, a nearly 14% increase from 2011 (VA Office of Public Affairs and Media Relations, 2016). Increased interest in such services has occurred alongside the VHA offering diverse trauma-focused didactic and training opportunities (Simiola, Smothers, Thompson, & Cook, 2018). The VA has also drafted, revised, and disseminated clinical practice guidelines for VHA providers to follow (Department of Veterans Affairs/Department of Defense, 2017) and collaborates with PTSD researchers to develop consultation programs designed to promote competency with such guidelines (Karlin et al., 2010).

John Correa

In addition to didactics, clinical practice guidelines, and consultation programs, effective trauma-informed supervision is another core element of VHA PTSD training programs. Trauma-informed supervision includes supervisory processes that increase knowledge and improve skills of supervisees providing trauma-informed services (Berger & Quiros, 2016). Providers delivering PTSD treatment often endorse high levels of exhaustion, burnout, compassion fatigue, and vicarious traumatization (Garcia et al., 2016; Voss Horrell, Holohan, Didion, & Vance, 2011), and trainees may be especially susceptible to developing these problems. Effective trauma-informed supervision could help minimize these burdens, and trainee perspectives can offer insight into how trauma-informed supervision could be impactful. This article describes anecdotal perspectives from two clinical psychology trainees on three beneficial elements of trauma-informed supervision received via an outpatient VHA PTSD Clinical Team.

Fostering Self-Awareness

We believe that effective trauma-informed supervision should promote trainee self-awareness of emotions, biases, identities, and beliefs that arise when delivering trauma-focused psychotherapy. Research has demonstrated that therapists' unchecked emotional expressions can increase resistance to treatment (Westra, Aviram, Connors, Kertes, & Ahmed, 2012), and that patients can sense negative feelings of their therapist (Wolf, Goldfried, & Muran, 2017). Further, awareness of cultural factors that either facilitate or restrict interpersonal connections with patients could enable trainees to identify sources of compassion fatigue and other contributors to negative patient outcomes. Therapist self-awareness is essential for competent delivery of trauma-focused psychotherapy, especially given the complex presentations of veterans diagnosed with PTSD.

Trainees delivering trauma-focused clinical services in a VHA setting often possess identities and belief systems that are different from those of the veterans they are treating. A trainee with no military history could be encouraged to explore whether this aspect of their identity might impact treatment progress with a veteran, someone whose cultural beliefs may differ given experiences like boot camp, deployments, and other aspects of military experience. The Guidelines for Clinical Supervision in Health Service Psychology (American Psychological Association, 2014) state that supervisors should seek to establish a working relationship with supervisees that possesses a caring dynamic and reinforces honesty, transparency, and professionalism in the supervisory relationship. Thus, consistent with these guidelines, effective trauma-informed supervision in a VHA setting could encourage exploration of trainee/veteran differences while discouraging avoidance of trainees' responses to veterans' disclosures. Such discussions could in turn foster self-awareness, facilitate self-discovery of reactions to sensitive topics, and improve understanding of individual thresholds for exhaustion and vicarious traumatization. Supervisors of trainees who treat veterans diagnosed with PTSD are therefore encouraged to assess for, propose coping strategies for, and make referrals for assistance for trainees' negative emotional reactions, including helplessness/powerlessness in the provider/veteran dynamic (Berger & Quiros, 2014).

Evidence-Based Assessment and Treatment

We also found discussion of the implementation of evidence-based assessments and treatments to be an impactful element of trauma-informed supervision. This component of the supervisory relationship allowed for rich discussions of case conceptualizations and collaborative determination of appropriate treatments given symptom severity and presentation. Effective supervisory recommendations regarding evidence-based assessments included the following:

1. Incorporate psychometrically sound self-report measures and interviews, including the PTSD Checklist for DSM-5 (Weathers et al., 2013), the Clinician-Administered PTSD Scale for DSM-5 (Weathers et al., 2018), and other measures to screen for comorbid psychiatric and substance use issues, as veterans with PTSD often present with co-occurring mental health disorders (Brown & Wolfe, 1994; Ginzburg, Ein-Dor, & Solomon, 2010).

2. Utilize automated, electronic questionnaire administration platforms if available, like the VHA's eScreening Program (Pittman et al., 2017). This program allows veterans' scores on self-report measures to be stored electronically and directly exported into their electronic medical records. Programs like eScreening enable discussion of a veteran's response to trauma-focused treatment and identification of barriers to treatment effectiveness (e.g., avoidance, poor attendance).

3. Record behavioral observations and qualitative perspectives provided by patients during clinical encounters and integrate such data with self-report measures to guide treatment decisions and case conceptualizations. We found supervisors' use of the "predisposing, precipitating, perpetuating" model of the development of PTSD (McFarlane, 1989) to be a useful method of case conceptualization when integrated into supervision meetings.

Jessica Tripp

Our perspectives on the benefits of evidence-based therapy-oriented supervision consistently corroborated recommendations found in the VA's Clinical Practice Guideline for PTSD (Department of Veterans Affairs & Department of Defense, 2017):

1. Supervisors should advise trainees to educate veterans about effective PTSD treatments, share resources from the VHA's National Center for PTSD, and engage in shared decision-making when selecting an initial course of treatment.

2. Supervisors should encourage trainees to implement manualized, individual, trauma-focused psychotherapies like Cognitive Processing Therapy (CPT; Resick, Monson, & Chard, 2017) and Prolonged Exposure Therapy (Foa, Hembree, & Rothbaum, 2007), whose theoretical rationales include cognitive restructuring and exposure components, respectively.

3. Supervisors should avoid excluding veterans from PTSD treatment if they have a co-occurring substance use/mental health condition, as engagement in trauma-focused treatment may not exacerbate co-occurring problems (e.g., Norman et al., 2019).

Socratic Method

A final aspect of trauma-informed supervision that we found to be effective was the use of the Socratic method during supervision meetings. Socratic dialogue is an integral component of cognitive therapies like CPT that facilitates self-realization of distorted cognitions and beliefs. The Socratic method also aligns with the developmental approach to supervision, which defines progressive stages of supervisee development from novice to expert (Stoltenberg & Delworth, 1987), and argues that supervisors should not provide supervision that is above the skill level of the trainee. Because trainees delivering CPT are learning skills in Socratic dialogue, the use of the Socratic method in supervision has two direct benefits: direct observation of the Socratic dialogue by the trainee and self-initiated discovery of burnout, compassion fatigue, and other common trauma-focused therapist reactions. Modeling of skills in supervision predicts skill implementation in therapy sessions (Bearman et al., 2013), lending evidence to the benefits of the use of Socratic questioning in supervision. That said, veterans with PTSD are often at high risk for suicide (Jakupcak et al., 2009), so blending Socratic dialogue with more directive supervision may be appropriate in cases when patients are at high risk of self-harm.

Conclusions

Exploring trainees' emotional reactions, encouraging measurement-based and evidence-based care, and incorporating Socratic questions into the supervisory relationship all reflect trauma-informed supervision practices that could enable trainees to become effective trauma-focused psychotherapists. These practices promote development of several profession-wide

competencies, including professional values, assessment, intervention, communication, and consultation, that are essential for clinical practice. Trauma-informed supervisors are encouraged to use open-ended questions and a trainee-centered orientation to supervision, as doing so enables more comprehensive conceptualization of PTSD presentations and ensures that trainee psychotherapists are engaging in adequate self-care. Trainees, in turn, are encouraged to engage in a case formulation process that jointly relies on validated, evidence-based assessments and qualitative observations and perspectives to ensure quality psychological care.

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Meaningfulworld 14th Humanitarian Mission to Haiti

August 16-25, 2019
Stepping into Health with Joy: 7-Steps for Healing our Mind, Body, Spirit & Mother Eart
Dr. Kalayjian, Dr. Midena, & Lorraine Simmons
In collaboration with Meaningfulworld Haiti Chapter
Ayiti se Lakay Mwen (Haiti is my home)

The Association for Trauma Outreach & Prevention (ATOP), www.meaningfulworld.com, NY Office: 185 E 85th Street, New York, NY 10028, Phone: 1-201-941-2266, E-mail: drkalayjian@Meaningfulworld.com

The Meaningfulworld team, Dr Ani Kalayjian, Dr Justina Medina, Lorraine Simmons and Arthur Jaffe embarked on the 14th Humanitarian Outreach Mission to Haiti in August. With ten days to accomplish numerous goals, we were prepared to work as efficiently and as diligently as possible while maintaining a balance with self-care which included healthy eating, supplements, soul-surfing, swimming and sleep. An important goal this year was to support and empower the newly formed Haiti chapter, led by Pastor Rubinson Dorce & Donie Marie Saint-Louime.

The first day, we attended the 9th Annual International CESSA Conference, sponsored by Center for Spirituality & Mental Health (CESSA), chaired by Fr. Jean Charles Wismick. The theme of the conference was Trauma and Mental Health in Haiti focusing on gratitude and meaning-making. This year there were over 500 attendees of some which serve their communities offering counseling in various ways with one third from religious orders, others included students from behavioral sciences as well as medical doctors, social workers, psychologists and administrators. At the CESSA conference, Meaningfulworld had the opportunity to present a clinical training as well as have Dr. Kalayjian as the closing speaker. Attendees at the closing workshop gave feedback stating that Dr. Kalayjian was energizing and uplifting. Fr. Wismick also shared feedback stating that he could see people respond to her with much enthusiasm. Dr. Kalayjian encouraged people to read authors that she finds most inspiring which include Maya Angelo and her mentor and former professor Viktor Frankl. She also encouraged Haitian attendees to become activists and stand up for and demand their United Nations Human Rights, and the Sustainable Development Goals, which includes free public education for all Haitian children, as well as gender equality and equity. Dr. Kalayjian offered to march with the group to the Ministry of Education to do this. In line with Dr. Kalayjian's philosophy of love and support the program ended with her signature heart-to-heart circle of love and gratitude.

Meaningfulworld's third day in Haiti was the last day

Working with girls in Life is Wealth Orphanage.

of CESSA International Conference in which we led intensive workshops. It was very rewarding to see attendees very engaged with curiosity and a quest to learn. Participants were guided through a Soul-Surfing energetic release and then gifts of earrings and essential oils were shared. The large numbers of attendees were so enthused by the workshop that they unexpectedly serenaded Dr Kalayjian several Haitian songs of gratitude. Afterwards, we received an overwhelming request for our literature in Haitian Creole and French by the hundreds of attendees.

During the CESSA conference, Arthur Jaffe also conducted a workshop on Spiral Technique; focusing on mind-body-connection! How emotions are held in the body and how negative emotions exacerbate pain! He guided participants in therapeutic stretches to release tension, pain and discomfort and regain a healthy body and a sense of well-being.

On the fourth day, Meaningfulworld Haiti chapter organized an intensive training, which was conducted at the Nazareen Theological Seminary. We covered the following topics: Self-care, Post-Traumatic-growth,

Emotional Intelligence (EQ), as well as individual, horizontal, generational, collective and vicarious trauma. It was a wonderful opportunity to help professionals feel empowered with knowledge and essential skills, which help them daily. We taught a group of 50 early career clinicians, which included: psychologists, social workers, counselors, teachers and priests. The training included the use of role-play to demonstrate challenging concepts such as assertiveness, empathy and mindful leadership. Frequently expressed feelings were fear, worry and sadness. Almost 90% have seen or experienced domestic violence against women; we encouraged them to take the peace oath, which all did, showing their commitment for peace. The exercises were the catalyst for the following initiatives: EQ campaign starting from kindergarten, teaching boys the value of respect, & being mindful of the cultural negative reinforcements. In addition, the 7-step Integrative Model was explained and practiced after lunch. In the setting of fresh air, cool breeze and majestic mountains we practiced Soul-Surfing, releasing negative emotions lodged in our bodies and through breath work and affirmations positivity replaced the negativity. Nearly half of the participants were so moved and inspired with our training that they committed to be part of Meaningfulworld Haiti Chapter.

For the fifth day in Haiti, Meaningfulworld continued the second day of Intensive training, which focused on meaning-making, forgiveness, conflict transformation and Visionary Leadership. In addition, homework assignments that Dr. Kalayjian had given the previous day were reviewed; journaling, breath work and disaster preparedness. The Meaningfulworld team felt appreciated and validated by the attendees' active listening, thought provoking questions and expression of their points of view. In addition, the training for the day included: role plays, reinforcement of assertiveness, recognition of passive-aggressive behavior, what empathy means and looks like, empathetic listening, and a review of "Four Agreements" by Miguel Ruiz. The training also included discussion and lessons on how to set limits and boundaries in a peaceful manner. Attendees gave feedback, which included statements of gratitude for the 2 days of training as well as their hunger for more training and workshops from Meaningfulworld. It is important to note that almost 1/3 of participants were male, which is encouragingly higher than previous years.

Day six in Haiti was a great day because we had new team members of our Haiti chapter accompany us on our training for supervision and fieldwork. The new team members were extremely helpful and were able to observe, assist and debrief. We had the privilege to train coast guard police officers and several members of the police department. The coast guard and police officers expressed their sense of duty to protect and serve their fellow Haitians. In addition, they stated that they face trauma daily and want to learn ways to release their stress. Thankfully our training included strategies to release their fears of ongoing gang violence and political unrest, worry of the political and economic distress, and embarrassment due to cultural pressures of masculinity. Part of our training encouraged attendees to express their feelings in order to prevent buildup of emotions, which could lead to physical ailments, domestic violence and child abuse. Our training also included assistance in the transformation of generational trauma (colonization), collective trauma (earthquake and gang violence), as well as individual and vicarious trauma. The energy lightened during our training when we moved through the Soul-Surfing exercises and affirmations. The attendees all expressed feeling much more at peace, empowered and energized to make a difference. It was especially rewarding to have the chief of the Haitian Coast Guard express his gratitude and his support of the work Meaningfulworld offers and invited us to return.

Meaningfulworld Haiti Day seven included working with physicians, medical students, psychologists, social workers, teachers, communication specialists, media, nurses and educators! When discussing domestic violence, we were presented with an opportunity of an invigorating, emotional, and passionate debate about sexual abuse and rape! Dr. Kalayjian held her own with approximately 12 men of the 100 participants who expressed inflammatory comments about causes of rape! They insisted that it's due to women's provocative clothing; while women were furious, jumping and yelling to defend themselves and reinforced that even nuns and older women are raped. While the men continued to deny male responsibility for viscous attacks on women, Dr. Kalayjian encouraged them to change their rigid beliefs, invited them to think about women as they think about their own sisters and mothers. The program moved forward with discussion of managing emotions and encouraged people to express their feelings while using words. Many people expressed worry about the future (political and economic uncertainty) and shame (due to rampant gossip derived from horizontal violence). Dr. Kalayjian explained the importance of expressing oneself to prevent pent up emotions turning into anger and then increasing the risk of domestic violence and child abuse. The participants were receptive and engaged. During a short breathing exercise people expressed feeling relaxed and reported that it was their first time experiencing this peaceful practice. Many people approached our team after the training and shared their delight with the program. They had in fact never experienced a healing workshop such as ours!

As day seven continued, it proved to be a real eye-opener; we faced some challenging occurrences that Haitians deal with on a daily basis. Upon completion of our morning program, we were determined to go to Bonjour Timoun orphanage but were deterred by several time consuming and frustrating occurrences. The

Clockwise from top: (1) Heart-to-Heart-Circle of gratitude & love after a workshop with Medical Physicians, Psychologists, social workers, educators and nurses! (2) 90% raise their arms to attests witnessing GBV, Physical & sexual abuse and rape! 3. Meaningfulworld 14th Haiti Humanitarian Relief Mission: Drs Kalayjian & Madena, Lorraine Simmons& Arthur Jaffe.

driver was stopped by the police and asked to provide the borrowed car's registration and insurance papers, after a period of intense waiting, with a fine issued and paid, we were on our way again. We were then made aware that the car was extremely low on gas thus posing the next challenge; locating a station that was selling gasoline. Haiti was experiencing a gasoline crisis, due to its political alignment with USA and not Venezuela, where they were receiving gas previously. The gas prices were predicted to be increasing in the next couple of days so; stations were closed to hoard it for selling for higher profit later. Upon locating an open station with long lines, we struggled to keep place in line with several lines of cars aggressively merging to get to the pumps. As we waited for almost an hour, (even turning engine off) the car ran out of gasoline. Thankfully, the car was close enough to be pushed to the pump. As always, the people who jumped in to help to push had their hands out for money and the person pumping the gas tried to swindle us out of $10 worth of gas. The driver was watching closely however and spoke up, it reinforced that one must always be on guard. The traffic was

horrendous, and a short distance took almost 3 hours. These are aggravating occurrences which challenge the Haitians daily, cause high frustration, and result in aggressive behavior. The kinds of challenges that wear people down and contribute to apathy and hopelessness. Our hope for Haiti is for peace, healing and love to prevail.

After the escapade of acquiring gasoline, we were disappointed that time would not allow for the visit to Bonjour Timoun. So, we went to our next appointment, Radio 98.5 FM for a dynamic conversation on the 1-hour live program "Go English Live." At Meaningfulworld the goal is to strive to reach people directly and indirectly and with the radio interview over one million listeners were reached! The dynamic and charismatic hosts Phedre Delinois and Kenel Joseph invited us into a conversation with enthusiasm. The hosts posed questions on how to empower and educate the Haitian people to break the pattern of generational trauma and horizontal violence and the importance of talking with children about emotional intelligence and gang violence. Phedre was particularly interested in breaking a pattern of non-expression with his 87-year-old father. He admitted that he has had great communication with his 7-year-old son but still hadn't been able to tell his father that he loves him. We could feel the hesitation and pain that Phedre had over this internal conflict that had been brewing for two years. During the live radio show our team encouraged him to express his feelings to his father and as he gained courage, he resolved to express his feelings to his father that night. The hosts were truly interested in gaining knowledge and did their research of Meaningfulworld, quoting Dr. Ani from a previous interview, "transforming our own traumas, discovering meaning, and using those new meanings and lessons as steppingstones for transcendence! From inner transcendence we feel empowered and help our family, community, Haiti and then the world." It was decided to continue the urgent dialogue to transform Haiti to Empowerment and peace! In the evening we received a phone call from Phedre; the pattern was broken, he had expressed his feelings of love to his father and to his delight, his father responded with, "I love you too, son." We were so excited that we were jumping up and down, hearts swelling with joy!

On the morning of day eight in Haiti we were welcomed and embraced by 62 young women and girls at the "Life Is Wealth" orphanage. Yves Lens Louis, the orphanage director is an enthusiastic man with a huge heart. We witnessed that all his interactions with orphans were filled with much patience and lots of love. Several people from the intensive training joined us at the orphanage to assist with translations and communication with the children. The first order of business was to feed the children, snacks we donated were basic: bread, bananas and water. Unfortunately, it is important to point out that the children are so malnourished that it is often difficult to estimate their age. Dr. Kalayjian

Meaningful World

Clockwise from top left: (1) Soul-Surfing with Orphans in Ganthier. (2) Transforming Vicarious Trauma In Proud Police & Coast Guards. (3) In spite of trainings police needed much needed physical release of fear and frustrations building Self esteem.

worked with the older group of young women who were encouraged to express their feelings and were taught the "Four Agreements," conflict transformation, and 7 steps for healing. The young women expressed feelings of jealousy and sadness and said they felt deprived. They stated that they want more clothing, to go to the sea, and to socialize more. We used that opportunity to encourage the girls to use the sewing machines to design and make one of a kind clothing, which served to spark their creative minds. Dr. Medina worked with girls that ranged from the ages of 11-14 and Lorraine worked with the youngest girls. Some of the children were very affectionate and showed their longing for attention and love while some were clingy, and some were standoffish which showed how desperate they were for affection. It was very heart-warming to see some of the girls proudly share their progress with their clothing designs and sewing skills, by showing off their clothing, which included skirts that they had created. The orphanage was appreciative to receive money that was so generously donated by Meaningfulworld sponsors. The funds will go toward purchasing another sewing machine and fabrics for the girls so they can continue learning and growing their skills.

The afternoon of day eight was especially meaningful because we were able to teach 30 children ranging from ages 5 to 12 at The Children's Academy, an inspirational school in Petion-Ville. The children learned about emotional intelligence, grounding, meditation and breathe work. They were very engaged in the exercises taught and they said they felt really good afterwards. When looking at the managing your emotions chart, the children were very expressive and gave examples of what different feelings look like. In addition, they learned about the "Four Agreements." The children found the exercises pertaining to the "Four Agreements" to be relatable and it inspired them to share their own real-life examples. The children gave feedback to their school's administrator stating; they now know more about emotions and how to keep themselves feeling balanced. While the children were learning about emotions and ways to balance their bodies, their parents and teachers were learning about self-care, managing their emotions, transforming generational trauma and Horizontal Violence. While participants awaited our arrival, they watched a video about a young disabled man who has an inspiring passion and joy for life, this message was reinforced by Dr. Kalayjian as she asked people how they felt learning about this man's story. They expressed that they too were inspired by his joy and positive attitude despite his disabilities. When discussing their feelings, many expressed that they worry about the future and as well as the past. We reinforced the concept of mindfulness and shared the mindfulness App, which could be downloaded for free on their phones. When asked how they view their purpose in life, many expressed that helping and serving god and others is most important. Generational trauma and horizontal violence were introduced as well as the concept of "The Crab in the Bucket." The director of the Children's Academy, Alex Myril is a special person who exudes joy for life, which is infectious and inspirational. The children, teachers and parents equally respect and adore Alex, he is a blessing to all who have the privilege to know him; an exemplary and compassionate leader.

While on mission, in addition to working with groups of people, we sometimes have an opportunity to work with individuals. Sadly, this year we were asked to meet with a 14-year-old girl who had been gang raped by 4 men (ages 19-21). We met with the young girl and her desperate but dedicated aunt. Regrettably, her story is one where the system has failed her, much like so many people who are left to fend for themselves in Haiti. Her relationship with her parents is extremely challenging, she is struggling with friends who are not trustworthy, she is feeling pulled by an older sister who leads her into dangerous situations, and she is feeling depressed and hopeless. The result is, she is making bad decisions for herself while putting herself at risk with drinking and going out with men much older than herself. We made it very clear however that she is not responsible for the horrible actions that these men made. They violated her and they alone are responsible. She presented as timid and slight in stature yet, she was willing to expose herself to us and hear what we had to say. We listened and empathized; we showed support and provided natural flower essence to help with the trauma and fear. We agreed with the aunt's decision to take the young woman to the appropriate doctors for treatment and that her choice in seeking a therapist who uses EMDR was a wise decision. The aunt felt supported, uplifted and thus felt empowered and energized to continue to support her niece.

Meaningfulworld Haiti Day nine was a day dedicated to working with a few orphanages in Ganthier. With the help of intensive training participants, we were able to present a simultaneous training to staff, administrators, teachers, nurses and social workers. These people are the first line of professionals that the orphans interact with daily, which means our work with them makes it so very important. The children, ages 4-11 were very excited to work with us and were very welcoming and affectionate. They were hungry for knowledge and were engaged in our meditation and breath work exercises, which revolves around emotional balance. The 7-Step Integrative Healing model was emphasized for the importance of expression of feelings for health and well-being. The children and adults convened for a large group of Soul-Surfing exercises where the children added a wonderful dynamic of energy and love.

By the tenth and last day in Haiti, we had rallied over 35 people to attend a morning meeting of the Haiti Chapter before flying back to the USA. This show of support is encouraging and energizing for the few dedicated people who kept the chapter alive throughout the year. We expressed sincere gratitude to Pastor

Rubinson Dorce, Kathleen Dorce, and Ms Valmond for holding the chapter together and for making the 14th mission to Haiti a success; with special gratitude to Donie Marie Saint-Louime for taking on the leadership of the local chapter.

During the 2019 mission we directly supported over 1,000 adults and children, and indirectly affected over a one million Haitians through several radio programs and several printed media sources. This year we worked very diligently to meet our ambitious goals and are confident that each goal was met:

1. Participated in the annual CESSA Spirituality and Mental Health Post Disasters, International Conference chaired by Fr. Wismick, with a lecture and a workshop
2. Taught a 3-day intensive training in Mindfulness, Emotional Intelligence, Forgiveness and Meaning-Making to professionals who will continue practicing after we returned
3. Taught & supervised the practicum for intensive program on the 7-Step Integrative Healing Model
4. Collaborated with the Minister of Education, and Minister of Health and Social Welfare to schedule a previously approved training with teachers and parents in northern Haiti; this goal was incomplete due to the upheaval in the government, and new ministers are not yet in position
5. Provided refresher educational programs for the orphanages, police, coast guard, schools, and communities
6. Taught the use of donated flower remedies (FesFlowers.com) and essential oils (Meaningfulworld.com) and discussed the importance of establishing "Peace and Forgiveness Gardens"
7. Continued with the "Crab in the Bucket" campaign transforming Horizontal Violence
8. Continued promoting "Ayiti se Lakay Mwen" campaign to bring awareness of environmental and ecological health, distributed banners to each organization
9. Surveyed multi stake holders (about 300) regarding impact of Meaning-Making and Forgiveness on levels of stress and trauma
10. Outreached to women's protection centers, and made introductory information sharing
11. Provided information on physical release and pain reduction through spiral techniques
12. Reinforced our meaningful connections with all our previous collaborative partners and empowered and assisted the continued development of Meaningfulworld Haiti Chapter.

The good news is that the MeaningfulWorld Haiti Chapter is now formally registered as a local Haitian NGO with the Ministry of Justice in Haiti. Congratulations to all!

Reflecting on the mission, Dr Medina shared the following, "What a wonderful and transformative experience it has been going to work alongside Dr. Kalayjian and the rest of the Meaningfulworld team. Haiti has so much natural beauty and the people we met and worked with are truly inspirational. They are all eager to learn, grow and support each other in a country that is constantly reinventing itself for better or worse. The Meaningfulworld Chapter in Haiti is such a vital component in helping Haiti change for the better. It has been a true honor and privilege to work with Dr. Kalayjian she is a true inspiration. Her strength, courage, vitality, energy and tenacity are remarkable. I feel lucky to work and learn from her. Thank you!" Lorraine Simmons states, "The people of Haiti are dealing with extremely dire circumstances to survive, it's a miracle that they are able to take care of themselves daily. I am privileged to work with a team of people in Haiti who are pushing through multiple challenges and have a dream for a safer, healthier, cleaner, and more peaceful Haiti. Thank you to the Haiti Chapter for your dedication, passion and vision."

Our motto is:
When one helps another, BOTH become stronger!

Founded in 1990, the Association for Trauma Outreach & Prevention (ATOP) Meaningfulworld, charitable organization affiliated with the United Nations Dept. of Public Information, has achieved international recognition as a leader in training humanitarian outreach professionals as well as responding to two and a half decades of global and local disasters. ATOP is committed to health, justice, peace, transformation and global education promoting state-of-the-art scientific theory on peace, forgiveness, consciousness research, internship, and the development of technical skills to train mental health professionals, teachers, psychologists, art therapists, nutritionists, alternative medicine practitioners, clergy, nurses, mediators, interfaith ministers, and lay persons committed to service the self and humanity. Meaningfulworld Humanitarian Outreach Teams have helped rehabilitate survivors from over 47 countries, and 25 states in USA making a daily difference in people's lives helping to transform tragedy and trauma into healing and meaning-making through post trauma growth, resilience, emotional intelligence, mindfulness, mind-body-eco-spirit health, visionary leadership, empowerment, artful collaborations, establishing Peace & Forgiveness Gardens to create a new and Meaningfulworld view. We work locally and globally in Africa, Asia, the Caribbean, Europe, the Middle East, The Caucuses, Europe, and South and North America

BRIEF REPORT

Vicarious Posttraumatic Growth in Therapists Working with Severe Mental Illness

Zachary Arcona, MS, Melissa LaCelle, MS, Sheila Santiago Schmitt, PsyD

Phenomena like burnout popularly plague mental health (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Therapists working with clients who have experienced trauma are even more susceptible to the characteristic symptoms of burnout, including exhaustion, cynicism, and feelings of inefficacy (McCormack, MacIntyre, O'Shea, Herring, & Campbell, 2018). When mental health professionals work in settings that increase demands on internal resources, particularly if they perceive their efforts to result in few positive outcomes, it results in chronic stress. The impacts of enduring chronic stress in the workplace can have negative repercussions for both physical and mental well-being. Examples of the consequences of burnout for therapists include deterioration of mental health (e.g., depression, anxiety), impaired physical health (e.g., sleep problems, neck and back pain, gastrointestinal distress), diminished sense of well-being, impaired memory, and substance abuse (Morse et al., 2012). Although not all professionals exposed to traumatic material develop burnout symptoms, related conditions are also highly prevalent, including compassion fatigue, vicarious traumatization, and secondary traumatic stress. Mental health workers most commonly report emotional exhaustion of the burnout dimensions (McCormack et al., 2018), but the wide-ranging severity of the impact of working with traumatized individuals can include symptoms that mimic posttraumatic stress disorder and ultimately lead to destructive changes in the professional's view of themselves, others, and the world (Baird & Kracen, 2006).

Zachary Arcona

Melissa LaCelle

A more positive aspect of providing psychotherapy for individuals with trauma is Vicarious Posttraumatic Growth (VPTG), an expansion of Posttraumatic Growth (PTG), which refers to positive changes in one's person from vicarious exposure to traumatic experiences (Arnold, Calhoun, Tedeschi, & Cann, 2005). PTG can create improvement in five discrete domains: relating to others, new possibilities, personal strength, spiritual change, and appreciation for life. These improvements can be seen in any number of these domains and do not necessarily appear in all 5 domains simultaneously. The vast majority of research in this field focuses on those who directly experienced trauma in an attempt to utilize positive psychology principles to encourage survivors of trauma (Calhoun, Cann, Tedeschi, & McMillan, 2000; Tedeschi, 2011). However, research recently began to shift in focus to include examination of VPTG in those working with trauma. Qualitative research conducted on psychotherapists and other mental health workers working with trauma has found evidence for positive gains from working with trauma present alongside the previously described negative effects (Arnold, Calhoun, Tedeschi, & Cann, 2005; Hyatt-Burkhart, 2014). Within the realm of VPTG, Cohen and Collens (2013) conducted an important metasynthesis that examined 20 qualitative studies. They found trauma work can not only create vicarious traumatic stress, but also short- and long-term changes in schemas and day-to-day routines that can be positive in nature.

The described research sets a basis for the prevalence of VPTG in therapists and others working with survivors of trauma. However, those working with serious mental illness (SMI) have never been researched assessed to examine the potential presence of VPTG. People diagnosed with SMI have a higher incident rate of trauma as evidenced by a systematic review of research on SMI cases that found the presence of physical abuse in approximately 47% of cases, sexual abuse in 37%, and post-traumatic stress disorder (PTSD) in 30% (Mauritz, Goossens, Draijer, and van Achterburg, 2013). Therefore, therapists working with SMI have likely been exposed to patient stories of trauma that could cause both vicarious trauma and growth. In response, we created a research project that examines VPTG in therapists working with

SMI in a psychiatric inpatient state hospital in the Southeastern United States.

The objective of our research is as follows: (1) examine potential correlates of VPTG and Vicarious Posttraumatic Stress, (2) investigate possible connections between VPTG and demographic variables, including age, gender, and level of training, and (3) inspect a correlation between VPTG and the Experienced Threat Scale.

Sheila Santiago Schmitt

The state hospital engaged in this study employs doctoral-level psychologists, post-doctoral students, interns, and practicum students (3, 0, 1, 4 study participants, respectively). Therapists in all of these groups, except post-doctoral students, completed the batteries following recruitment and all participants were female. Each participant completed the Posttraumatic Growth Inventory Short Form (PTGI-SF), the Secondary Posttraumatic Stress Scale (SPTSS), the Experienced Threat Scale, the Stress-Related Growth Scale, and a demographics form. A modified version of the PTGI-SF measured VPTG in accordance with previous literature that used versions of the PTGI when testing this construct (e.g., Lambert & Lawson, 2013). The demographics form included age, gender, years worked with trauma, level of psychology training, religion, percentage of caseload with PTSD symptomatology, a Likert scale (1-10) rating the therapist's belief of the most severe trauma he/she worked with, and personal experience with PTSD. An important note of clarification is the difference between PTG and stress-related growth. PTG postulates that a complete shattering of an individual's schema is necessary in order for growth to occur, which often entails severe trauma. However, stress-related growth opines a wider range of experiences can facilitate growth, such that a total shattering of the schema is unnecessary. This distinction suggests that stress-related growth is more common than PTG; therefore, utilizing measures of both constructs allowed for a more thorough investigation of potential growth in these therapists.

An initial analysis of descriptive data found evidence for VPTG within this small sample size of mental health workers. First, total scores on the PTGI-SF showed growth to a small degree due to their work, with scores ranging from no growth to a great degree of growth. Further, different categories on the PTGI-SF yielded significantly different scores. Both "New Possibilities" (NP) and "Spiritual Change" (SC) had mean scores indicating change to a very small degree while "Relating to Others" (RTO) showed a small degree of change. "Personal Strength" (PS) and "Appreciation of Life" (AOL) found scores indicating moderate growth. Due to the varying degrees of PTG within samples, an examination of the range of scores can provide great insight. Within all subareas of the PTGI-SF, scores varied from no growth to moderate growth (NP), a great degree of growth (RTO, SC, and AOL), and a very great degree of growth (PS). On the Stress-Related Growth Scale, scores indicated that the therapists experienced growth "somewhat" due to their experiences working with SMI. Finally, there is little evidence for the presence of secondary traumatic stress within this sample. While traumatic stress symptoms were initially believed to be a necessary component for VPTG, these results support recent research that indicates the opposite; traumatic stress symptoms are not needed for the development of PTG or VPTG.

Burnout and related problems take a powerful toll on psychologists and other mental health workers. While the introduction and understanding of PTG to these populations may not fully ease the burden of suffering they carry, the positive nature of growth can provide powerful relief and reframing. This research begins to set the initial framework by demonstrating that therapists working with SMI can experience VPTG and stress-related growth, even in the absence of posttraumatic stress symptomatology. This initial small study with a limited sample size needs to be expounded on to create a larger literature base. For instance, the sample consisted solely of women and the results may not generalize to men. We plan to continue to grow our study and collect a larger sample to help assist in this literature base. However, additional, more elaborate studies can assist. For example, a wider examination of correlates to VPTG in these populations would help strengthen and further this field of inquiry. Previous studies have repeatedly found correlates related to PTG such as social support and positive rumination (Soo & Sherman, 2015; Shand, Cowlishaw, Brooker, Burney, & Ricciardelli, 2015), but have thus far neglected VPTG. An investigation of these variables could be the next step in the literature development to indicate that VPTG not only exists in this population but can be facilitated with the knowledge of its important correlates.

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Similarity between Non-Consensual Sharing of Images and Sexual Assault: Questions about the Construct Validity of PTSD

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Klein and Zaleski (2018) conducted research on classifying the non-consensual sharing of images as sexual assault. The authors conducted a qualitative analysis on issues focused on the intersection of sexual assault and other forms of sexual violence, including revenge porn. They note that victims do feel trauma secondary to revenge porn, viz, shame, post-traumatic stress. They further note that post-assault symptoms associated with a sexual assault such as shame, self-blame, psychophysiological symptom, and hypervigilance also pertain to an individual who has had sexual images shared in a non-consensual way. Researchers at USC School of Social Work note similar symptomatology produced by both revenge porn and sexual assault survivors, viz, loss of trust, self-blame, anxiety, depression, suicidal ideas, and PTSD.

This author has conducted forensic and clinical assessments on patients who are victims of non-consensual sharing of sexual images. In the cases of these patients, although the target events for PTSD, viz, a victim of a violent event or witnessing a violent event are not met, these patients display many of the symptoms of PTSD, viz, hypervigilance, intrusive, repetitive thoughts, triggering of events in the environment by a discriminative stimuli. Moreover, this author posits that non-consensual sharing of intimate images is a violent act, viz, an individual's privacy and boundaries are taken from them and distributed to others.

The author posits that this lack of fit between the DSM-V criteria for PTSD and symptomatology of victims of non-consensual image sharing and cyberbullying is due to problems with the construct validity of PTSD. (Hermosilla, 2018) relates that reliability and accurate conceptualization of the structure of PTSD is essential to the development of effective assessment and treatment. Her study on the 2010 Haiti earthquake survivors noted a lack of congruence of the DSM-V construct to a culturally diverse sample. Her study also found that the DSM-V model had the poorest relative fit for her sample compared to the anhedonia model. Similarly, there are problems with the DSM-V model of PTSD lack of capturing of the population of victims of cyberbullying and non-consensual image sharing.

(Klein, 2018) at USC posits that victims of non-consensual image sharing and cyberbullying display symptomology similar to victims of sexual assault. This author has found this to be true in clinical practice. Victims of non-consensual image sharing and cyberbullying, display symptoms of PTSD, viz, intrusive repetitive thoughts of the trauma, hypervigilance to the environment, psychophysiological symptoms, triggering of distress by discriminative stimuli in the environment, triggers of the traumatic event, shame, survivor guilt and distortion of body image. Assessment of these patients reveals similarities to sexual assault victims, viz, loss of control over the privacy of body boundaries, victimization, and exploitation. This is yet another example of a group of individuals who do not present an exact fit to the DSM-V consistent with PTSD. As with samples of refugees, and other diverse populations, the DSM-V construct of PTSD does not capture these important populations who are beset by trauma and victimization.

Practitioners are urged to consider the similarities of symptomatology and the trauma matrix between both groups of sexual assault victims and victims of cyberbullying and nonconsensual image sharing in their assessments and treatment plan. These individuals undergo significant suffering and emotional distress. First and foremost, treatment should provide support and address issues with self-esteem.

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Listening Inside to the Pain of Life: A Session Excerpt

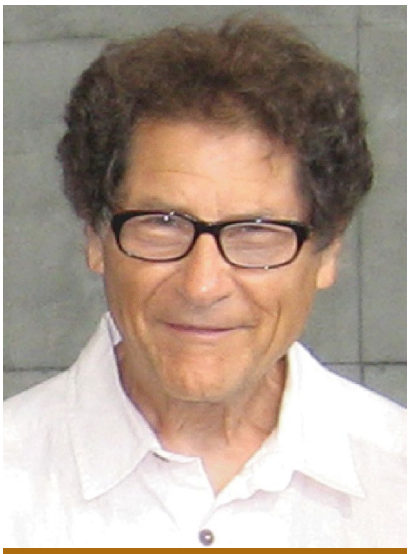
Michael Eigen, Ph.D.

Psyche Singing

M.E: "Wondering what you hear when you listen inside."

A.G: "When I listen inside? When I listen – I hear screaming."

M.E: "Does it ever stop?"
A.G: "Right now I'm thinking I don't listen to it all the time so I don't always hear it. But maybe it goes on all the time. I'm not sure if it stops or I just don't listen. It might go on all the time, a scream that never stops. But I stop listening. I do other things. Do you think I should spend my whole life listening to myself screaming? What good would that do?"



Michael Eigen

M.E: "Do you listen to it sometimes?"

A.G: "I'm afraid to. I hadn't thought of it before, but I try not to. I try not to hear it. It's like a ringing inside."

M.E: "Where? Does it have a place?"

A.G: "It changes. It could be in my head or ears. But I think it's mainly in my chest."

M.E.: "Where your heart is?"

A.G: "My heart and maybe lungs."

M.E: "Breath and pulse?"

A.G: "My heart is screaming. My breath is screaming. I close my mind. Now I think I close my soul. My soul doesn't want to hear its own screaming, but it wants me to hear it."

M.E: "And what will you do with it? What does your soul want?"

A.G: "It wants me to feel it. Maybe greet it, say hello, spend time with it, be with it."

M.E: "Get to know your deep scream?"

A.G: "Yes, get to know it.

M.E: "Can you say what it's screaming about?"

A.G: "Maybe just the pain of life. How painful life can be. How painful it is to be alive."

M.E: "Is the pain unbearable?"

A.G: "It can be, yes. But not always. Now I feel it comes and goes. Now more, now less. Maybe it is not always the same. Maybe it is not always unbearable but sometimes it is. Often is."

M.E: "So there is room to feel other things besides pain."

A.G: "Many other things. But now I am thinking that my fear of pain stops me."

M.E.: "Stops you from breathing? Being?"

A.G: "I didn't think before how painful breathing might be. Now I'm feeling afraid to breathe."

M.E: "It's a very real fear. Can you breathe with the pain, into it? Breath with the fear?"

A,G: "I can try. It's scary but I want to. I want to be able to breathe. And as I say that I feel the pain spreading, thinning out, turning into something else – I'm not sure what."

M.E: "What's on the other side of pain?"

A.G: "Tears." [A.G. weeps, quietly at first, then sobs, chest heaving.] "I feel I'm trying to stay alive."

M.E: "I get the thought that at some point in your life pain kept you alive, made you feel alive."

A.G: "But at some point, it got stale, dull or worse, stopped me from living. Right now, it's dissipating, turning into a different sensation. I'm not sure what it is. Something between tears and pleasure but not quite either. A quiet something, just there. A sensation you get when you squeeze your muscles from the inside. A squeezy kind of sensation."

M.E: "I think I know what you mean, at least a little bit of it. A kind of inner squeeze that makes your insides feel better."

A.G: "Yes. I can squeeze myself from the inside, a soul squeeze. It's not just a matter of doing away with pain and tears but something else."

M.E: "Are you saying there's room for all of them?"

A.G: "Yes, there's room for all of them."

Michael Eigen, PhD *is author of twenty-seven books and many papers. He teaches and supervises at New York University Postdoctoral Program in Psychotherapy and Psychoanalysis and the National Psychological Association for Psychoanalysis. He has been Editor of The Psychoanalytic Review, received the Lifetime Achievement Award from the National Association for the Advancement of Psychoanalysis and Hans Loewald Award from International Forum of Psychoanalytic Education. He gives a private seminar on Winnicott, Bion, Lacan and his own work ongoing forty-five years.*

International Committee Report

Elizabeth Carll, PhD, Chair

Elizabeth Carll

During the past decade the number of forced migrants including refugees and asylum seekers has reached crisis proportions with the highest historic levels of migration. Children separated from their families have made headlines around the world. Responding to the needs of refugees requires a variety of roles by psychologists. The symposium, ***The Diverse Roles of Psychologists in Working with Refugees and Immigrants*** was organized at the 2019 APA Convention in Chicago to highlight the various ways psychologists can help provide support. Participants included Sita Patel, Claudia Antuna, Brigitte Khoury, Betsy Gard, and Diana Prescott. Elizabeth Carll chaired the event and Nadine Kaslow served as the discussant. The symposium received excellent feedback from the attendees.

Christina Silvera

To encourage participation of international students at the APA convention, Division 56 offers a **$1000 International Student Travel Stipend** to support travel to the convention. A free one-year membership in Division 56 is also included. The stipend is intended for international students enrolled in a graduate program in psychology, who are citizens of and live and study in developing countries or are citizens from developing countries studying in the U.S. who will be presenting a trauma related poster, paper or participating in a symposium at the 2019 APA convention. The recipient of 2019 Travel Stipend to the APA Convention in Chicago was Christina Silvera from Jamaica, a graduate student working toward her master's degree in Clinical Psychology at The University of the West Indies. She presented a poster at the APA Convention on young women's perception of aggression.

A thank you to Jyothi Vayalakkara, Felicitas Kort, and Laura Captari, who served as the selection subcommittee of the International Committee to determine the recipient.

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

Social Media News

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

Book Review: *Cognitive Processing Therapy for PTSD: A Comprehensive Manual*

Resick, P. A., Monson, C. M., & Chard, K. M. (2016). *Cognitive Processing Therapy for PTSD: A comprehensive manual*. New York, NY: Guilford Press. ISBN 9781462533725

Reviewed by: Merdijana Kovacevic, M.S, and Elana Newman, Ph.D.

Cognitive Processing Therapy for PTSD: A Comprehensive Manual contains everything a provider needs to deliver Cognitive Processing Therapy (CPT), an evidence-based treatment for posttraumatic stress disorder (PTSD). CPT aims to help clients acknowledge "stuck points", thoughts that keep survivors from recovery after a traumatic experience. Clients are encouraged to accept the reality of what happened and develop balanced thoughts about themselves, others, and the world. An updated treatment manual was needed, as research determined a written account of the index trauma event, a critical component of previous manual versions (e.g., Resick, Monson, & Chard, 2014), is not essential for CPT's efficacy (Resick et al., 2008). Hence CPT was reformulated to focus primarily on cognitive therapy addressing trauma-related thoughts about safety, trust, intimacy, power/control, and self-esteem. This new accessible manual describes the updated format in four sections providing: a) the theoretical underpinnings of CPT; b) treatment considerations; c) an in-depth guide of major treatment components; and d) helpful tips to adapt CPT to client needs.

Meridijana Kovacevic

In Part I, Resick provides an engaging autobiographical description of CPT theory development, evolution, and dissemination. Using both her clinical experience and scientific acumen, she describes how her team recognized serious treatment gaps for sexual assault survivors. Resick traces the theoretical underpinnings of CPT, including the influences of cognitive theory and the constructivist self-development theory of traumatic victimization. She notes the gradual development of CPT, which involved doubting the prevailing conceptualization of PTSD as solely a fear/anxiety disorder early on. She reported incorporating the biological model of PTSD to inform CPT techniques. Lastly, a concise review of research examining the efficacy and effectiveness of CPT is provided regarding primary outcomes, such as PTSD, and secondary mental and physical health outcomes, such as sleep changes. This section is likely to become outdated quickly as the database on CPT continues to grow.

The overall treatment approach and considerations are discussed in Part II including for whom CPT is appropriate and when and how to implement CPT. A plan to conduct a comprehensive pretreatment assessment of trauma history, PTSD symptoms, and other comorbid health conditions is provided. Easy-to-copy assessment tools, such as the PTSD Checklist-5 (PCL-5; Weathers et al., 2013) and the Patient Health Questionnaire-9 (PHQ-9; Kroenke & Spitzer, 2002), and charts to track client progress are included. The manual emphasizes how to conceptualize cases based on client's stuck points to inform treatment planning. Specifically, the manual reviews the need to first identify and target client's problematic assimilated thoughts, in which a client changes their interpretation of the event to fit existing beliefs (e.g., "I should have prevented the trauma"). Then, the manual suggests tackling problematic over-accommodated thoughts, or trauma-related changed beliefs about the self, others, or the world (e.g., "No one can be trusted"). In this section, information regarding trauma-informed ways to use general techniques is presented, such as using clarification to explore and challenge clients without invalidating their experiences.

Part III provides a detailed session-by-session guide to implementing CPT. For each session, there are new agendas, example scripts, and handouts (e.g., Trust Star Worksheet). The manual specifies indicators of progress throughout the protocol, which easily allows providers to concentrate on a primary focus for each session. Examples of critical CPT assignments and concepts are thoroughly described, which may be especially helpful to novice providers. For instance, this manual provides an annotated transcript of how to identify stuck points in clients' accounts of their ideas about the causes and the impact of the trauma. Multiple solutions to deal with obstacles, such as non-adherence, are provided. Furthermore, specific advice on conceptualizing and reframing common themes for trauma survivors are discussed. For example, during the power/control module, compulsive behaviors (e.g., rechecking locks)

may be conceptualized as behaviors leading to less control.

Part IV addresses special adaptations of CPT both in format (e.g., individual or group) and to different populations. Special considerations are discussed for individuals who are: active-duty service members and veterans, sexual assault survivors, intimate-partner violence survivors, disaster-accident survivors, and adolescents. Considerations on how to adapt CPT for those who have cognitive deficits, or PTSD complicated by grief also is reviewed. Session-by-session overviews are provided of different forms of CPT, including CPT for sexual abuse. While the basic tenants of CPT may be applied across cultures, current evidence for cultural adaptations is thoroughly reviewed. Considerations regarding racial/ethnic diversity, sexual orientation diversity, religion, morality, and other languages are directly addressed, which are often stumbling blocks for even the most proficient providers. A major strength of this manual is its consideration of diversity in delivering a standardized but flexible protocol.

Elana Newman

Throughout the manual, considerations of client and provider's most common concerns and difficulties in engaging with the CPT protocol are discussed. The manual helps providers anticipate how to respond to client concerns in a trauma-informed and sensitive manner. For instance, if a sexual assault survivor communicates self-blame, a provider can normalize this response and can help the survivor differentiate what was unforeseeable (i.e., an accident) and who played a role in the event with the intention of creating harm (i.e. fault). To help the provider, solutions to overcoming treatment providers own stuck points regarding CPT are presented in a helpful questions-and-answers section. This approach to addressing clinician internalized factors may be particularly appealing to psychodynamic providers.

This book is useful for Division 56 members and others who want to provide an empirically-supported treatment for PTSD. The authors took the opportunity to elaborate, offer hints, and guidance at every step of the way, given their expertise with CPT. This comprehensive manual would be helpful to both the novice CPT provider, as basic tenants of the treatment are thoroughly explained, along with advanced CPT providers, as technical nuances and potential adaptations of treatment delivery are detailed. This all-inclusive manual contains the necessary components required for clinicians to provide CPT, including new handouts that make the revised manual worth the purchase. Overall, *Cognitive Processing Therapy for PTSD: A Comprehensive Manual is a must-have for the trauma provider.*

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The PTSD Checklist for *DSM-5* (PCL-5). Scale available from the National Center for PTSD at www.ptsd.va.gov.

Merdijana Kovacevic, M.A. *is Doctoral Candidate at the University of Tulsa (TU) under the mentorship of Elana Newman, Ph.D. She is interested in elucidating effective programming and/or empirically supported treatments for populations at high risk for developing PTSD.*

Elana Newman, Ph.D., *McFarlin Professor of Psychology at the University of Tulsa, is the Research Director at the Dart Center for Journalism and Trauma and a Co-director of the Tulsa Institute of Trauma, Adversity, and Injustice. Her work focuses on assessing, understanding, and treating maladaptive responses to traumatic life events; Current projects focus on the intersection of journalism and traumatic stress studies and child disaster mental health.*

Comorbid Posttraumatic Stress Disorder and Obsessive-Compulsive Disorder

David Rhee
Boston College

In the interest of transparency, I would first like to disclose my background and interest in posttraumatic stress disorder (PTSD) and obsessive-compulsive disorder (OCD) comorbidity. As a master's-level intern in the clinical assessment team at the McLean Hospital's Obsessive-Compulsive Disorder Institute (OCDI), I conduct diagnostic intake interviews that span the primary dimensions of the DSM-5 with a particular focus on conceptualizing patients' obsessive-compulsive symptoms. Virtually all of the patients admitted for treatment at the OCDI present with moderate to severe OCD. According to Dr. Van Kirk, head of clinical assessment at the OCDI, about 55% of current patients at the OCDI endorse having experienced a traumatic event at some point in their life, while only around 10-15% of current patients meet criteria for a PTSD diagnosis. Currently within our field, the term 'comorbidity' is used in reference to cases where two or more illnesses are simultaneously present in a patient. This paper advances the perspective that, in some cases, comorbid OCD and PTSD interact in ways that are beyond merely additive, potentially resulting in important implications for treatment.

David Rhee

Both scientific research and clinical observations in the field of mental health support the idea that comorbid diagnoses in patients more often represent the rule rather than the exception. In particular, the extremely high rates of comorbidity linked to PTSD suggest that the diagnosis almost always develops in the context of other mental disorders such as Major Depressive Disorder (Koenen et al., 2008). Research has shown that OCD also disproportionately affects patients with PTSD. While the rate of OCD is 1% in the general population, approximately 30% of PTSD patients have either been previously diagnosed with OCD or develop symptoms that meet criteria for an OCD diagnosis within 12 months of receiving a PTSD diagnosis (Brown et al., 2001; Badour et al., 2012).

The OCDI administers Exposure and Response Prevention Therapy (ERP) as the evidence-based treatment of choice for patients with OCD (Hezel et al., 2019). In essence, ERP involves repeatedly exposing patients to their worst fears and anxiety triggers. Through coaching, patients gradually learn to control their compulsive responses, habituate to their triggers, and manage their anxiety in more adaptive ways. ERP takes a hands-on, head-first approach to recovery. For patients with a trauma history, and patients with treatment-resistant OCD in particular, evidence suggests that posttraumatic intrusions disrupt the effectiveness of the habituation process at the core of ERP (Shavitt et al., 2010; Dyskhoorn, 2014). Research and case studies also suggest the possibility that, for at least some patients with comorbid OCD and PTSD, a dynamic connection between symptoms of both disorders can exist, where treatments successful in reducing OCD symptoms inadvertently lead to an increase in PTSD symptoms, and vice-versa (Rachman,1991; Gershuny et al., 2003). Treatment that does not take into due consideration the interactions involved in comorbid PTSD and OCD diagnoses, such as whether a certain intrusive thought is better accounted for by a patient's PTSD or OCD, has the potential to result in outcomes that project an illusion of progress without actually providing effective therapy.

Uncontrollable, intrusive thoughts that lead to distress and impairment comprise a hallmark symptom of both PTSD and OCD. Intrusive thoughts in OCD, or obsessions, are characterized by speculative thinking and excessive doubt regarding anxiety-provoking outcomes (APA, 2013). For example, patients with contamination OCD may feel severely distressed by the uncertainty over whether their hands may still be dirty despite excessive washing. Intrusive thoughts in PTSD, on the other hand, stem from a past traumatic event. Unlike OCD obsessions, intrusive thoughts in PTSD tend to reference back to a previous trauma, similar to other PTSD-related intrusive symptoms such as flashbacks or recurring nightmares.

Interplay between OCD and PTSD can occur when past traumatic experiences act as evidence to support the excessive labeling of otherwise improbable, speculative obsessions as threatening (Sasson et al., 2004). In addition to patients having access to experiential data for irrational fears, they are also being reminded

either consciously or subconsciously of the event itself. Responsible practice must take into account that administering ERP to help a patient habituate to an obsession that causes traumatic re-experiencing is not the same as if that obsession was unrelated to trauma. When symptoms of PTSD surface in ERP treatment, clinicians are responsible for attending to the patient's emotional processing and providing an immediate perception of safety.

Trauma exposure can lead to the formation of persistent and exaggerated negative cognitions (APA, 2013). These trauma-related cognitions will threaten, call into question, or sometimes completely shatter certain worldviews and core beliefs in relation to one's sense of safety, self-worth, or trust in others. Often, traumatized individuals present with a heightened sense of responsibility and lowered sense of self-esteem due to these negative cognitions (Dykshoorn, 2014). While OCD obsessions trigger fear and anxiety through similar schemas concerning safety or self-worth, most patients with OCD possess fair to good insight over their symptoms (APA, 2013). When a patient shakes with mortal fear at the prospect of touching a dirty doorknob, clinicians may opt to dismiss their fears as unrealistic or imaginary. The majority of patients would agree, despite being unable to dismiss their fears with the same ease, as the DSM-5 suggests that only around 4% of patients with OCD present with absent insight or delusional beliefs (APA, 2013). It has also been suggested that patients with OCD possess an exaggerated sense of personal responsibility for their obsessions (Gershuny et al., 2002). Some may equate the mere thought of performing a taboo action to be the same as performing it. Others may feel personally responsible for performing a ritual in order to prevent disaster from befalling their loved ones. Unlike trauma-related cognitions, OCD obsessions are more likely to be associated with a compulsion.

OCD compulsions are ritualistic, often repetitive behaviors aimed at subduing the anxiety caused by obsessions. Some compulsions may be directly connected to the underlying fear, as with hand-washing rituals and contamination obsessions. In other cases, they may only be loosely related or not at all, such as with patients who feel that they must count, pace, or clap a certain amount of times to protect loved ones from unrelated disasters. Rather than adopting compulsions or rituals, patients with PTSD are more likely to develop hypervigilance and avoidance symptoms (APA, 2013). Both compulsions and hypervigilance behaviors provide a sense of safety to the patient upon completion, reducing their anxiety. In some cases, hypervigilance behaviors can overlap with certain compulsions, such as checking behaviors involving locks, windows, or perimeters. To outside observers, both compulsive and hypervigilant behaviors may be interpreted as excessive, ritualistic, or irrational. The main difference, however, is that hypervigilant behaviors, like trauma-related cognitions, stem from trauma and serve the perceived function of preventing the trauma from reoccurring, regardless of whether the threat has passed or how likely the event is to repeat itself (Rachman, 1991). The interpretation of cognitions and obsessions is a complex process that involves metaphorical and associative thinking as much as, or perhaps even more than, logic.

Although case studies certainly cannot serve as complete scientific evidence, consider the following synopsis of a patient presented by Gershuny et al. (2003) that may help illustrate the aforementioned concepts: Ms. A., a patient with severe PTSD and OCD, obsesses over the unlucky number '54,' the age at which her stepmother was murdered by her father. Though even the patient herself is able to acknowledge that her preoccupation with the number '54' is superstitious and irrational, clinicians' attempts to expose Ms. A to the number '54' elicited trauma-related fears and cognitions including "I am in danger," "I am not in control," and "someone who was supposed to take care of me was capable of murder." Over the course of ERP treatment, Ms. A. developed more depressive symptoms and reported increased severity of trauma-related intrusions, numbing, social withdrawal, and avoidance behavior. Gershuny noted that, while her obsessions and rituals appeared to decrease initially, they re-intensified in frequency and duration following treatment. While this case study should be taken into consideration as mostly anecdotal evidence, Ms. A. serves as an example of a treatment-resistant patient who could potentially benefit from further inquiry into the effects of traumatic intrusions on the success of ERP therapy.

Although the primary scope of the present article involved OCD and PTSD comorbidity, complex interactions between mental illnesses are not limited to only these two diagnoses. Particularly, one area of interest for further research may be interactions between Borderline Personality Disorder, PTSD, and OCD (particularly Relationship-OCD). Another area of interest may be concerning the effects of Major Depressive Disorder on PTSD treatment outcomes in terms of potentially increased rates of suicidality and treatment dropout.

When PTSD exists in tandem with other diagnoses such as OCD, clinical pictures can vary in dynamic and complex ways that one line of secondary diagnosis cannot sufficiently reflect. Taken in light of the clinical implications that comorbidity can have on patients' healing, new methods of conceptualizing trauma are necessary. In order to provide effective and responsible care for patients, clinicians are encouraged to strive for relationships that yield information beyond the manualized definitions of diagnostic criteria. Creating change on an institutional level can be arduous and slow, but pushing the limits of individual competence is an actionable endeavor upon which all clinicians in the field have the ability to act.

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David Rhee *is a 2nd-year candidate for a Master's degree in Mental Health Counseling at Boston College. He currently works as a clinical assessment intern at the Obsessive-Compulsive Disorder Institute at McLean Hospital in Belmont, Massachusetts. His primary interests within the field involve topics surrounding trauma, OCD, Asian-American issues, narrative therapy, qualitative research methods, and refugee mental health.*

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.

Who's Who:
Viann Nguyen-Feng, Ph.D.

1) What is your current occupation?

Currently (as of this past August…), I serve as core faculty in the Department of Psychology's counseling/clinical master's program at the University of Minnesota, Duluth. I head the Mind-Body Trauma Care Lab and teach Multicultural Foundations, Personality and Diagnostic Assessment, and Psychology as a Discipline and Profession. Every day is different, and I love it.

2) Where were you educated?

Most of my schooling covers the two states in which I was born and raised: Maryland and Virginia. However, I found my way to the Midwest to pursue a counseling psychology PhD on the University of Minnesota's Twin Cities campus. My positive experiences in Minnesota, the university as well as the state, have led me to stay.

Viann Nguyen-Feng

3) Why did you choose this field?

Service as a professor in the field of trauma psychology is the best combination of everything the third-grade version of me wanted to be "when I grew up": an author, a teacher, a doctor, and a detective. Because inclusivity is the core underlying value that drives me, I was first drawn to work in public health and then to counseling and trauma psychology. I wonder about those who feel unseen, those who hurt others, those who hurt emotionally and physically, and how all these overlapping groups may access the best, holistic mental health care.

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

The best part is seeing when my teaching and research directly connect to others' lives. I don't want my teaching and research simply to be intellectual exercises (for me or others) but lived experiences from which individuals can readily benefit. Because I see learning about oneself as a necessary precursor to learning about and serving others, it's rewarding to watch "lightbulb" moments when students' self- and other-awareness meet. My hope is that students can take what they've learned and apply it to their own lives and the lives of those they encounter. Similarly, because I tend towards community-based and interventional research, I feel lucky that part of my work allows me to foster interpersonal connections with some amazing organizations and people.

5) What is most frustrating about your work?

The most frustrating part of this work may be acknowledging and accepting that there are things in which we may never truly know—but that doesn't mean we have to stop seeking the answers.

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

Each day, I try to create space for me to be active as well as still. To integrate activeness into my day, I commute via walking, biking, or "hiking" (there's a sliver of the Superior Hiking Trail near me)—I might try snowshoe commuting this winter! To integrate stillness into my day, I created a Zen room in my home, just a simple place to sit, reflect, and be.

7) What are your future plans?

Broadly, I hope to be part of the revolutionary discourse that is part of trauma psychology's future. There are deeper policy and practice changes that can be made in the areas of mind-body interventions, emotional trauma, access to care, and more—and I seek to be a part of those conversations.

Photo credit to Bobby Rogers / Walker Art Center

Cordially invited: Refugee family discourse

What do you see? Is it New Tara, the plantation of the twenty first century?

Crops of dreams and disasters lay juxtaposed as biproducts of influential forecasters. It makes you wonder what Hitler and Prophet Muhammad (صلى الله عليه وسلم) would have been like in toastmasters.

Crops have been placed in the fertilizer of society's sycophant adages. Sown and harvested via the compass of left and right-wing baggage.

Social relationships have redefined community stability. With trailblazers like Cervantes and Durkheim outlining the strength in human fragility.

Now, transnationalism, influential in navigating life courses, shepherd the new era of social transformations. For example, our hunter-gathers now make Uber reservations.

In light of our changing world, darkness is still present. It has grown stronger and sown seeds of discontent.

Natina Roberts

A world of unease and duress is what some live in. This habitat has materialized through the normalization of suffering; tied with an uneven social-reciprocity ribbon.

Families say, "We saw death, its stare was treacherous." They continue saying, "… thankfully death didn't see us."

Getting on boats; rowing away their fears, not knowingly docking into fear o'er again. A newfangled pandora's box opened; releasing the asylum-vintage's aromatic pandemonium.

Almost airborne, the pungent scent of stigma, dead-end family reunification, and broken resettlement frameworks, waft through the air. A shared breeze encompasses the world in a humanitarian nightmare.

In such situations, the UNHCR distributes empathy gift cards. The problem is these are not redeemed. The recipients are too busy fortifying their safeguards.

Walls of mass destruction, take that how you will, break families apart and reduce refugee quotas to the size of ant-hills.

Ironically, the average reflex when looking at an anthill are symptoms of chills. It gives a new meaning to the phrase seeking cheap thrills.

Society, feeling as if magically imbued with some infectious disease, lacks safe responses to war and atrocity.

Living tombs of detention and encampments are made. Disappointingly, world leaders are completely unfazed.

However, intergenerational consequences may yet lead to resilience and invigoration of kin. This lets you know the trump card doesn't always win.

SDGs present a load of crop.
Albeit good intentions, is a global humanitarian chop-shop.

Inhumanely we pick and choose who to support. Displacing proletarian persons; bringing shame to the Nansen passport.

Who is responsible? Who is to blame? We always want to point the finger to make it easier to see ourselves, like Dorian Gray.

Which family has sown these seeds? Whose historical trauma and chronic pain is a cash-crop guaranteed?

Tell me, what do you see in a refugee family? What are the stories that shape us and what are these narratives redefining?

Are they forced migrant or migrant families? Is the distinction important to navigate dysfunction globally?

Now, the next time someone opens your oyster shell and questions your worth, let them know your origins aren't a mystery. You are from the earth.

My words aren't mystic, they are simple heuristics, only a supremist would argue with something so realistic.

Natina Roberts *is a creative, driven, health-sciences professional with 9+ years' experience in mental health advocacy and teaching. She has been involved in safety, wellness and self-sufficiency initiatives for diverse community groups – of varying ages – (nationally and internationally). She has a strong background in research, education and advisory. She is currently pursuing her doctoral degree in family psychology and the University of Auckland in New Zealand. Her PhD work is with forced migrant/refugee families.*

PTSD and Suicide: How Emergency Department Clinicians Can Intervene

Amanda Wallick, BS & Lisa Brown, Ph.D., ABPP

Suicide is one of only three leading causes of death in the United States that continues to increase (Stone et al., 2018). In 2016, World Health Organization statistics estimated that nearly 45,000 suicides (123 suicides per day) occurred in the U.S. among people aged 18 and older. Among the U.S. military, suicide rates of active duty service members now surpass rates within the general population (U.S. Department of Veterans Affairs, 2016). In addition, from 1999 to 2015 deaths by suicide increased among all racial/ethnic groups, both sexes, and all age groups of those under the age of 75 (Stone et al., 2018). Despite a slew of new initiatives that have been recently implemented by various government and non-government agencies to prevent deaths by suicide, suicide in the U.S. remains a national public health concern.

Amanda Wallick

Trauma is a well-documented risk factor for suicidal thoughts and behaviors (LeBouthillier, McMillan, Thibodeau, & Asmundson, 2015). A diagnosis of posttraumatic stress disorder (PTSD) is one of the strongest predictors of both recent and lifetime suicide attempts, with a comorbid diagnosis of depression and PTSD further amplifying the risk for suicide (Bryan, 2016). Research also indicates that individuals diagnosed with PTSD who, at some point, experience suicidal ideation (SI) have an increased likelihood of transitioning to a suicide attempt compared to those who are diagnosed with other psychiatric disorders (Nock et al., 2009). Therefore, providers who treat clients with a trauma history and/or those diagnosed with PTSD are urged to continually monitor and assess for SI using well-validated assessment measures.

PTSD often includes somatic problems that motivate patients to seek treatment in either primary care or emergency department (ED) settings (Greene, Neria, & Gross, 2016; Onoye et al., 2013). Given this, one place that mental health clinicians may be able to successfully identify and intervene for those most at risk for suicide is in EDs. From 2001 to 2016, rates of ED visits for nonfatal self-harm, a primary risk factor for suicide, increased by 42% (Stone et al., 2018). In addition, it was estimated that as many as one in ten individuals who died by suicide had been seen in an ED during the prior two months (Bowers et al., 2018). This observation highlights EDs as a crucial setting for suicide assessment and prevention. As ED psychiatric services are frequently required to assess a high number of patients and provide a clinical opinion about their future risk for suicide, the need for reliable and valid suicide assessment protocols is critical.

Risk Factors Associated with Suicide Assessment Instruments

Identifying standardized instruments that can reliably and validly assess suicidal behavior has been a focus of research for decades (Cochrane-Brink, Lofchy, & Sakinofsky, 2000; Cull & Gill, 1988; Jobes & Drozd, 2004; Russ, Kashdan, Pollack, & Bajmakovic-Kacila, 1999; Yufit & Lester, 2005). A recent systematic review suggests that researchers developing these instruments have typically focused on identifying and validating risk factors and sets of suicidal predictors in order to assess a person's risk of suicide (Runeson et al., 2017). These risk factors have been reported to cluster into two domains: socio-demographic factors and clinical factors (Bisconer & Gross, 2007; Large et al., 2011). Some of these factors include: a history of deliberate self-harm, hopelessness, male gender, substance use, unemployment, feelings of guilt or inadequacy, social isolation, depressed mood, a family history of suicide, and a diagnosis of bipolar disorder or schizophrenia (Cull & Gill, 1988; Large et al., 2011; Links & Hoffman, 2005; Ruiz, 2001; Russ et al., 1999; Stack & Wasserman, 2005).

Researchers have identified clients seen in inpatient settings as a subpopulation that presents with slightly different risk factors for suicide compared to those who are seen in outpatient clinical settings (Large et al., 2011). A history of a suicide attempts was the strongest predictor of death by suicide among inpatients. Moderate predictors include depressed mood, a family history of suicide, being prescribed an antidepressant medication, a diagnosis of schizophrenia, and feelings of hopelessness, worthlessness, inadequacy, or guilt (Large et al., 2011). Interestingly, weak predictors for in-patient suicide included a higher number of previous psychiatric admissions and a suicide attempt at the time of admission (Large et al., 2011). Additionally, this meta-analysis identified no demographic factor as

significantly associated with inpatient suicide (Large et al., 2011). Moreover, physical illness, co-morbid substance abuse, the presence of hallucinations, delusional beliefs, or treatment with antipsychotic medication were also *not* significantly associated with suicide for patients receiving inpatient care (Large et al., 2011).

These research findings underscore the difficulty of relying on a singular assessment tool to detect all of the varied risk factors when determining suicide risk. Although, these research findings suggest that specific socio-demographic factors and clinical factors contribute to an individual's risk for suicide, setting also influences an individual's potential risk. It is clear that each of these factors must be thoroughly considered when designing, selecting, and utilizing an assessment tool that will help a clinician predict an individual's risk of suicide.

Selection of an Assessment Instrument

Ideally, each high-risk patient seen in a hospital setting should be assessed with a clinical interview in addition to a measure that can reliably and validly detect factors that may place them at an increased risk for suicide. Overall, current research is clear that assessment instruments should never be a substitute for a clinical interview, as interviews can address multiple areas of a patient's life that may be contributing to their increased risk for suicide (Links & Hoffman, 2005; Podlogar et al., 2016; Stone et al., 2018). Assessments should be used to augment a clinical interview and the results should be used to inform the clinician's decision to hospitalize or discharge the patient. Some of the most widely accepted instruments used to detect risk of suicide include the Beck Anxiety Inventory (BAI; Beck & Steer, 1993a), the Suicide Probability Scale (SPS; Cull & Gill, 1988), the Adult Suicidal Ideation Questionnaire (ASIQ; Reynolds, 1991), the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001), the Beck Scale for Suicide Ideation (BSS; Beck & Steer, 1993c), the Beck Hopelessness Scale (BHS; Beck & Steer, 1993b), and the Beck Depression Inventory II (BDI-II; Beck, Steer, & Brown, 1996).

Research at a psychiatric hospital evaluated the ability of the SPS, ASIQ, BSS, BHS, BDI-II, and the BAI to distinguish between patients who were admitted for suicidal behavior and patients admitted for other reasons (Bisconer & Gross, 2007). Results indicated that the BAI, BHS, and BSS, while face valid for suicidal behaviors, did not perform as well as the SPS, ASIQ, and BDI-II. Additionally, while the SPS and ASIQ were specifically designed to assess suicide behaviors, results suggested that the BDI-II was the overall best predictor of suicide risk compared to the SPS and ASIQ (Bisconer & Gross, 2007).

In addition, Baryshnikov et al. (2018) used the BDI, BHS, and the BAI to identify which scale best detected risk for suicide by inpatients in context with the patient's personality characteristics as measured by the BIG-5 Inventory (McCrae & John, 1992). Results of their study revealed that suicidal inpatients with high levels of neuroticism and extroversion were best identified using the BHS (Baryshnikov et al., 2018), Moreover, having a low level of perceived social support increased the predictive validity of the BHS with these patients, helping to explain both state and trait variations of hopelessness as it relates to risk for suicide (Baryshnikov et al., 2018). These results suggest that an individual's personality traits also influence the usefulness of a suicide risk assessment measure.

Lisa Brown

The PTSD and Suicide Screener (PSS; Briere, 2013) is a less known, 14-item self-report measure that is designed to quickly screen for PTSD and suicide risk. This screener contains two scales: the PTSD Risk (PR) and the Suicide Risk (SR). The SR contains four items that assess for suicide risk. The PSS is effective as a quick indication that a patient may be experiencing SI. However, its limitations include the nuanced ways that SI is experienced among individuals, which may not be fully captured in fourteen questions.

Results of these studies highlight a major limitation of existing assessment measures; relying on single-construct measures such as PTSD, depression, hopelessness, historical factors, or level of overt suicidal intent to determine an individual's risk of suicide (Hawes, Yaseen, Briggs, & Galynker, 2017). It is evident that single-construct assessment measures are not able to adequately capture all of the nuanced ways that setting, sociodemographic, cultural, and personality characteristics influence a person's risk for suicide. This may also help to explain why, to date, there is no singular assessment instrument that demonstrates predictive validity for death by suicide (Runeson et al., 2017). An additional limitation of using a single construct assessment measures is missing data. Research shows that when participants skip suicide risk screening items it does not occur completely at random (Podlogar et al., 2016). Selective nondisclosure by inpatients can be intentional and is likely to predict a subpopulation of respondents who have some level of elevated risk, based on the information they *do not*

endorse (Podlogar et al., 2016). Missing data could lead a psychologist to mistakenly discharge an inpatient if they do not identify and address the specific items that the patient skipped.

In general, these limitations highlight the need for hospitals to use suicide risk protocols that encompass multiple assessment instruments in order to capture all of the unique factors that could contribute to a patient's increased risk for suicide.

Future Directions for Risk of Suicide Assessment Instruments

To address the lack of multi-factor assessment instruments, recent suicide risk assessments have turned to a multi-informant approach for assessing a patient's risk for suicide. The Modular Assessment of Risk for Imminent Suicide (MARIS) was developed to assess a patient's short-term suicide risk following hospital discharge (Hawes et al., 2017). This assessment instrument combines both the patient's self-report and the clinician's evaluation of the patient's risk for suicide into one singular score (Hawes et al., 2017). Interestingly, the patients' self-report does not contain items overtly referring to their suicidal history, ideation, or intent but the clinician's portion of the assessment does (Hawes et al., 2017). It is the combination of these two scores that define an inpatient's short-term risk for suicide (Hawes et al., 2017). Results of Hawes et al. (2017) suggests that the MARIS demonstrated adequate predictive validity for detecting high-risk psychiatric inpatients who will engage in suicidal behavior during the four to eight weeks following hospital discharge. This research identified the use of multi-informant approaches as a promising area for future directions within the field of suicide risk assessment instruments.

Conclusion

As clinicians, our ethical principles dictate that we do our best when assessing patients who express SI and intent (APA, 2013; Bongar, 1991). Assessment instruments that measure risk of suicide include the BAI, SPS, ASIQ, PHQ-9, BSS, BHS, BDI-II, and the PSS. Overall, results indicate that using single factor assessment measures are problematic due to the varied and nuanced ways that patients' characteristics influence a variety of risk factors that increase their risk for suicide. Recent advances in suicide risk assessment measures have demonstrated predictive validity for multi-informant approaches, making these a prominent area of future research. These types of approaches are aligned with APA guidelines that outline the usefulness of both a clinical interview and an assessment battery to adequately evaluate a patient's risk for suicide. While death by suicide remains a national public health concern in the U.S., EDs have a unique opportunity to identify and intervene for those most at risk, in part through the creation of valid and reliable assessment measures.

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Amanda Wallick *graduated from the University of Nevada, Las Vegas in 2016, with a Bachelor's in Psychology and a Minor in Marriage and Family Therapy. In 2017, she began the Clinical Psychology Ph.D. program at Palo Alto University (PAU), where she recently completed the Trauma Area of Emphasis. Amanda has first-authored a book chapter on resiliency and mental health and a previous Division 56 newsletter contribution looking at the importance of trauma core competencies in graduate programs. She also served as PAU's secretary for the Association of Traumatic Stress Studies student group for the 2018-2019 academic year and was recently elected as APA Campus Ambassador for PAU. Her research interests include trauma/PTSD, severe mental illness, and personality. She is a student affiliate of APA Division 56, the Association for Psychological Science (APS), as well as the International Society for Traumatic Stress Studies (ISTSS).*

Lisa M. Brown, Ph.D., ABPP *is a tenured Professor, Director of the Trauma Program, Director of the Risk and Resilience Research Lab at Palo Alto University, and faculty advisor for the Association of Traumatic Stress Studies. Her clinical and research focus is on trauma and resilience, global mental health, aging, and vulnerable populations. As a researcher, she is actively involved in developing and evaluating mental health programs used nationally and internationally, drafting recommendations aimed at protecting individuals and communities during catastrophic events, facilitating participation of key stakeholders, and improving access to resources and services. Dr. Brown is a Fellow of the American Psychological Association and the recipient of two Fulbright Specialist awards with the University of the West Indies, Mona, Jamaica (2014) and with Massey University, Palmerston North, New Zealand (2015).*

DIVISION 56

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

Call for APA 2020 Submissions

Advancing Trauma Research, Practice and Policy Through Reciprocal Collaborations

Our diversity, in expertise and in viewpoints, is our strength. Without doubt, diversity can create disagreement and conflict, which can be challenging. However, abundant personal, community-based and global examples prove that working through such challenges provides an opportunity through which growth and transformation, and increased cohesion, peace, well-being and effectiveness in reaching goals can be achieved.

For APA 2020, Division 56 is putting together a program that will inform readers on the state of the science for conciliatory models; provide examples of effective *bidirectional* collaborations between trauma research, practice, advocacy, and/or policy beyond the well-established practice of translating science into clinical work; and offer a roadmap for researchers, clinicians, and policy advocates to more effectually achieve our shared goals of preventing trauma and decreasing its negative effects.

Although all proposals relevant to Division 56's mission will be considered, we are requesting submissions for research presentations/symposia, panels, skill-building sessions, think-tanks, and posters on such topics as: cost-benefit analysis of unidirectional (e.g., translation of science into practice) and bidirectional models of collaboration; examples of and/or methodological research regarding effective models of reconciliation, depolarizing communication, grassroots collaborations, and bidirectional models of collaboration between research, practice, advocacy and/or policy. Please also consider submitting a collaborative session with other APA divisions that approaches a single topic from multiple perspectives.

Proposals for cross-divisional *collaborative sessions* are due **Oct. 11, 2019**. All other proposals are due **Dec. 2, 2019.**

Any queries can be addressed to the Program Co-Chairs at: div56.chairs@gmail.com

Program Co-Chairs:
Carolyn B. Allard, PhD, ABPP, CSPP at Alliant International University, University of California, San Diego, CA
Susan Hannan, PhD, Visiting Assistant Professor, Lafayette College, Easton, PA
Lynsey R. Miron, PhD, Clinical Supervisor, Rogers Behavioral Health, St. Paul, MN

Genocide, Trauma, & Forgiveness

Annual meeting at the APA 127th Convention in Chicago
Conversation hour at Trauma Psychology
Saturday, August 10, 2019

Margarita Avedisian, PhD, Licensed Clinical Psychologist

Armenian Behavioral Scientists and guests gathered at the American Psychological Association's 127th Convention on Saturday, 10 August 2019. The theme of the meeting was Genocide, Trauma, and Forgiveness. The guest of honor was **Jackie Kazarian,** a visual artist, educator, and an activist! She is known for visually challenging and kinetic images that integrate painting and drawing with screen printing, stamping, flocking and collage. She taught painting and drawing at The Art Institute of Chicago and has created installations and videos for dance companies.

Dr. Takooshian, Professor of Psychology at Fordham University, and Founder of ABSA welcomed participants to the celebration, and conversation hour hosted by the APA Trauma Prevention Division. He then invited Dr. Kalayjian, the Chairperson of the program. **Dr. Kalayjian** expressed gratitude to participants and introduced the artist who talked about her recent theme of forgiveness for healing and transformation. She began by healing herself, and the generational trauma of the Ottoman Turkish Genocide of Armenians and other Christian minorities in Asia Minor.

Dr. Kalayjian, then presented ***ABSA Medal of Honor*** to Ms. Kazarian, for her lifelong artistic contributions to humanity, and her activism to help the Armenian community heal from generational impact of the genocidal trauma.

In 2015, Ms. Kazarian created *Armenia* project which included the "***forgiveness series***," which explores forgiveness as a personal act of volition. The Armenian word to forgive is "neroum" integrated with cultural references-church floorplans and illuminated manuscripts all intertwined with her grandmother's traditional Armenian lace tatting from Marash, and Aintab, Anatolia.

Ms. Kazarian refers to "***Forgiveness & Transcendence***," from an Essay by Dr. Ani Kalayjian in the Psychology periodical *Clio's Psyche (1999)*, describing her struggle to help Armenian elderly Genocide survivors "integrate the trauma, find meaning in their suffering, and move on to the next stage of their life."

The Forgiveness series is currently exhibited at FAVA Gallery, Oberlin, Ohio. For more info kindly contact www.JackieKazarian.com.

Oscar Tatosian, Honorary Consulate General for the Republic of Armenia to Chicago, followed with his welcoming remarks, sharing his experiences and knowledge of Ms. Kazarian, and announced that one of Kazarian's paintings is hanging in the US Embassy of The Republic of Armenia.

A very lively Q&A followed, participants grappling about how to forgive in absence of acknowledgement and in presence of denial for over 104 years. A reception followed, as Drs. Kalayjian and Takooshian expressed gratitude to Dr. Lynsey Miron, the chairperson of APA's Trauma Division's Programming, who facilitated the logistic of the event.

For the next APA Convention next year, August 6-9 in Washington, DC 2020 kindly visit www.APA.org, for monthly forgiveness workshops, kindly contact Dr. Kalayjian at drkalayjian@meaningfulworld.com; to join ABSA kindly contact Dr. Takooshian at Takoosh@aol.com.

Be Part of the Conversation

Division 56 was founded to keep trauma and its effects at the forefront of the conversation within the American Psychological Association. We are focused on bringing together clinicians, researchers, educators, and policy makers to ensure this goal is met across all domains of practice. Join us and contribute to this conversation by submitting to one of our publications, posting on social media, participating in one of our committees, or running for a leadership position.

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You can become a part of the Division of Trauma Psychology today by registering online at:

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*Professional Affiliate Membership is offered to individuals who are not members of APA. Applicants must submit a description of professional training in trauma psychology or a related field, a c.v., and the name of a current member willing to provide a brief statement of endorsement. These materials should be submitted to the Membership Chair at division56membership@gmail.com

Division of Trauma Psychology
Division 56 of the American Psychological Association

2019 Division Council

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Loren M. Post, Ph.D. (Term ends 12/31/21)
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Lisa Rocchio, Ph.D., Chair (Term ends 12/31/19)
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Dawn Hughes, Ph.D. ABPP (Term ends 12/31/20)
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Council Representative from Division 56 to APA (1 year, completing Joan Cook's term)
Steven N. Gold, Ph.D. (Term ends 12/31/19)
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Christine Valdez, Ph.D. (Term ends 12/31/19)
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Members-at-Large to Division 56 EC (3 years, renewable for one consecutive term)
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Carlos Cuevas, Ph.D. (Term ends 12/31/20)
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Jack Tsai, Ph.D. (Term ends 12/31/21)
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Position Selected by President and Search Committee:

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Positions Selected by Journal Editor-in-Chief

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

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DIVISION 56
TRAUMA PSYCHOLOGY
AMERICAN PSYCHOLOGICAL ASSOCIATION

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

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