DIVISION 56

TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

NEWS

Presidential Voice

Sylvia Marotta-Walters, Ph.D.

Welcome Message

The news every day seems to provide a panoply of potentially traumatic experiences (PTE) affecting our families, our political systems, and our global society. At the time of this writing, families are hearing that their loved ones have lost their lives in an airplane crash. Communities are bracing for yet another catastrophic storm, introducing new phrases such as "bomb cyclones" and "polar vortices" to characterize extreme weather conditions. Relentless school shootings continue to happen, resulting in children having to learn to cope with active shooter drills starting in kindergarten. This is also a world where parents are forced into a Sophie's choice – stay in a homeland that threatens their children with a life of violence, if not death, or risk losing them to a broken immigration system in a country that is hostile to the kinds of attachments that are fundamental to healthy human development.

Because our social systems appear to be in chaos, I've chosen as my presidential theme, "Developing well in a traumatizing world." What this means is that all of us who are

exposed to these PTEs are going to continue to unfold our developmental pathway, while navigating through all kinds of adversities. Human beings are remarkably adaptive and in that resilience lies our work as trauma psychologists. This year's convention program will present a symposium on developmental repair, functional improvement, and symptom reduction for those who experience all forms of trauma, so that our treatments can promote healing from extreme exposures such as those described above.

The #MeToo movement helps victims of sexual assault find a voice and a virtual place to belong, but it's important to emphasize that we also have the science to help people with these experiences make meaning from them. We provide treatment guidelines that help us as practitioners determine the best fit, taking into account client preferences and sound empirically supported treatments. Division 56 members are contributing professional practice guidelines to complement the clinical practice guidelines that were approved by APA last year. Division 56 also is working on a joint project with the International Society for Trauma

and Dissociation (ISSTD), that will suggest guidelines for the treatment of complex trauma.

Joint projects are excellent ways of providing the public with resources that can be used to promote resilience. At the time of this writing I am exploring a project with the International Society for Traumatic Stress Studies (ISTSS), our sister organization in trauma, to craft a resource for practitioners who work with child trauma, to supplement those on assessment and treatment overviews that were done a few years ago. I am also exploring a possible joint project with the National Child Traumatic Stress Network (NCTSN) with a child treatment focus. We will provide more information on these in the coming months.

Turning more toward our own professional development, at our Mid-Winter Meeting in February, the Executive Council approved the formation of a Division 56 Task Force to study how to move the competencies for trauma psychology

Sylvia Marotta-Walters
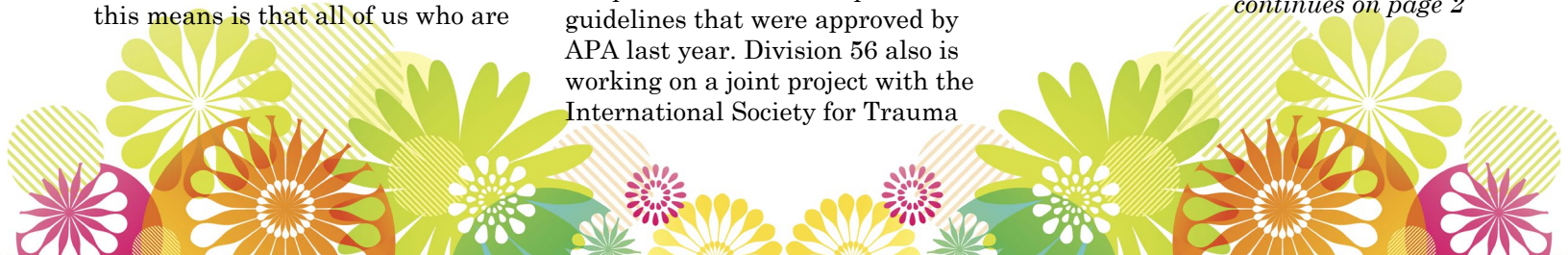
to the next level of institutionalization. These are the Guidelines that were developed by our own members, Joan Cook and Elana Newman, along with a group of trauma experts, during the New Haven Trauma Conference in 2014, and which were approved by APA in 2015.

The Division also is working very closely with our new Executive Director, Lee Claassen, who joined us this past fall, and who is already making a world of difference in our efficiency and our productivity. I hope you will get to meet her during our Annual Meeting in Chicago.

In conclusion, I am looking forward to 2019 as a year when Division 56 contributes clarity and compassion to our profession and our society. I hope to see all of you in Chicago.

2019 EXECUTIVE COMMITTEE

Division of Trauma Psychology Division 56 of the American Psychological Association

2019 Division Council

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Greetings,

Jonathan M. Cleveland
Editor-in-Chief

Welcome to an expanded spring issue of *Trauma Psychology News.* The earlier portion of the current issue is devoted to a special section on the topic of dissociation. We are fortunate to have Dr. Tyson Bailey serving as the guest editor for this section. Dr. Baily is a former editor of *TPN* and a current associate editor of *Psychological Trauma: Theory, Research, Practice and Policy.* Please visit the following page for his introductory note.

Later in the issue, you will find an excellent feature article on an application of the New Haven Core Competencies to a curriculum of trauma training at Palo Alto University's Ph.D. program, a timely piece (in the student spotlight) on attachment trauma suffered by immigrant children facing separation or deportation, and a review of Laurie Kahn's book *Baffled by Love: Stories of the Lasting Impact of Trauma Inflicted by Loved Ones.* There is also a compelling piece on gender-based violence in Caribbean communities, an interesting review of cognitive-behavioral conjoint therapy for couples experiencing PTSD related to loss of a child, as well as updates from the International Committee and the Refugee Mental Health Network. In the final pages of the issue, we present announcements from Dr. Irit Felsen about the UN Trauma Working Group, from Dr. Ani Kalayjian about the current and future projects of ATOP Meaningful World, and from Dr. Priscilla Dass-Brailsford about the Fellows Committee. Finally, take a moment to swing by the Who's Who section to meet active Division 56 executive committee member, Dr. Bryann DeBeer.

The editorial team would like to thank you for being a reader of *TPN* and a supporter of APA's Division 56. We encourage you to send submissions for inclusion in our summer issue by June 3rd.

Best,
Jon

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

IN THIS ISSUE

Guest Editor's Note

Tyson Bailey, PhD

During my internship year, I sat in group supervision listening to the story of a person who had experienced horrific abuse coming to understand the effects of these repeated experiences over time. This client moved from a place of terror toward curiosity about their internal world and how dissociation helped protect them from the intensity of the abuse and their emotions. Listening to my colleague honor this survivor's story while they came to know their parts and how each one has been integral in their survival was a powerful learning experience. Then, the person was admitted to a hospital where a psychiatrist stated "Dissociation is not real; your therapist is an idiot." I will never forget the gut-wrenching feeling I experienced as a removed observer to this situation, which I can only imagine is a fraction of what the survivor experienced after this invalidation of their lived experience. I hope we move toward a time where such stories are talked about in the same manner as "there was a time when sticking ice picks in people's brains was believed to be therapeutic," where we can validate the amazing ways human physiology can adapt to egregious, repeated harm to body and self. It is toward this goal that I am honored to present *Trauma Psychology News'* special section on dissociation.

This section begins with Bryan Reuther's overview of dissociation and some of the difficulties we have experienced as a field creating a parsimonious definition. Paula Thomson provides a look into dissociative strategies utilized by athletes and performing artists, focusing on how these may help or hinder performance and development of self. In an exciting development for assessment of dissociation, Ana Abu and colleagues have constructed a validity scale for the Dissociative Experiences Scale that may be helpful for clinicians and researchers. From a treatment perspective, Hugo Schielke and colleagues provide information about the TOP DD studies, a series of studies about the treatment of living with dissociative disorders. Utilizing the phrase "it's just a donut," Lynne Harris discusses a case example of helping a client regulate her physiology and reduce the impact of dissociation on her daily functioning. Robert Stolorow's article highlights psychoanalytic views on the effects of dissociation and how healing may be experienced. Finally, Charles Benincasa and I discuss the effects of invalidation experienced by many individuals who utilize dissociation

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to survive unspeakable horror. We then call on trauma psychologists to be unified in acknowledging the legitimacy of Dissociative Identity Disorder.

Trauma psychologists are in a unique position to validate dissociation—a neurobiological mechanism that can become problematic when circumstances require overreliance on this strategy (Frewen & Lanius, 2006a, 2006b; Liotti, 1992; Schore, 2009). Although authors continue to state dissociation is controversial, the research base verifying this experience across psychological and neurophysiological realms is becoming increasingly robust each year. In accordance with this research base, the proposed criteria for dissociative identity disorder in the International Classification of Diseases-11 (World Health Organization, 2018) removes any mention of controversy or being a culturally-bound experience from the diagnostic description. It was not so long ago that individuals who experienced symptoms after exposure to trauma were viewed as weak, otherwise deficient, or at worst, fabricating their symptoms for attention or other type of gain. The cultural shift toward recognizing the effects of trauma has provided validation that is not consistently extended to those living with one or more symptoms on the dissociative spectrum. Trauma psychologists have a long history of pushing the boundaries and fighting for an inclusive recognition of the widespread and potentially enduring effects of trauma across the lifespan; let's not stop now.

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Three Problems with Dissociation
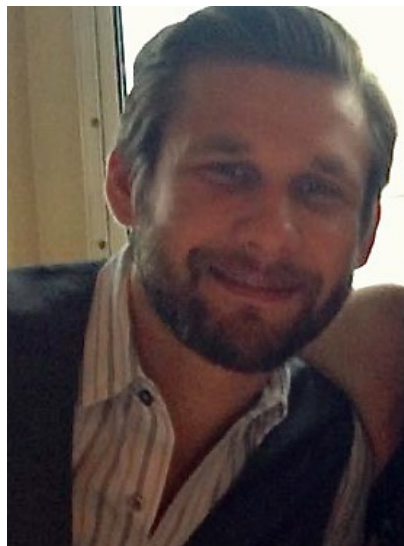
Bryan T Reuther, PsyD

In the minds of clinicians and researchers, the term 'dissociation' conjures up a variety of intriguing and controversial phenomena; it should therefore come as no surprise that some have complained that the term is vague and imprecise (Cardeña, 1994; Frankel, 1994; Spitzer, Barnow, Freyberger & Grabe, 2006). Complaints notwithstanding, there is little disagreement that dissociation has been, and will remain, an important part of human psychology (Erdelyi, 2005), particularly as a reaction to trauma. Moreover, dissociation challenges the assumption, and the very nature of, unity in human experience. Consequently, dissociation deserves serious attention from scientists, clinicians, and theoreticians – both for its own sake and for advancing our understanding of fundamental structures of human psychology.

The aim of this paper is to bring into view three problems that any adequate understanding of dissociation will need to address. In order to articulate these problems, I will draw from relevant figures and moments in the history of dissociation. I refer to the three problems as the *motleyness problem, ontological problem, and normative problem,* respectively. My main point is that if we do not have adequate answers to these problems then our conception of dissociation, especially a rich phenomenological articulation, will remain vague and imprecise. I will conclude with some thoughts about how to proceed.

I. The Motleyness Problem

In psychology, the term 'dissociation' has come to encompass a wide range of different phenomena, including daydreaming, depersonalization, derealization, dissociative amnesia and dissociative fragmentation— and this is far from an exhaustive list. While all are considered forms of dissociation, each is characterized by a distinctive presentation and phenomenal character. For example, the phenomenology of depersonalization, such as an 'out-of-body' experience, is quite different than the phenomenology of identity fragmentation in

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dissociative identity disorder (DID). In this section, I will briefly sketch the development of how the term 'dissociation' became the label of so many distinct phenomena, and how this generates a problem—the motleyness problem—that an account of dissociation needs to address.

The vast majority of dissociation researchers and clinicians credit the French psychologist-philosopher Pierre Janet for the discovery of dissociation—although dissociative phenomena certainly existed prior to Janet's discovery, notably theorized in terms of animal magnetism and spirit possession.[1] Janet (1907) identified dissociation as the major feature of cases of somnambulism and hysteria, with the assertion that the model of somnambulism was the basis for more complex cases of hysteria. Somnambulism in the late 19th century went beyond mere sleepwalking to include states where a person would speak and act as though they were conscious, yet not recall what occurred during that time (the person would be amnestic to what occurred while in the somnambulic state). Janet (1907) understood somnambulism to involve the "dissociation of an idea, that has emancipated itself from the ensemble of consciousness" (p. 173). For Janet, the hallmark of somnambulism was this division of consciousness, and the formation of two separate conscious streams: the conscious and subconscious. The subconscious stream formed around an *idée fixe,* or *'fixed idea',* which was often the result of an extremely stressful or traumatic event. This fixed idea would not be integrated into the 'normal' consciousness and persist in various levels of complexity. Thus, for Janet, dissociation is a failure of integration, with the result being the formation of these subconscious ideas.

While Janet established the role played by dissociation in the pathologies of somnambulism and hysteria, on the other side of the Atlantic, the American physician Morton Prince expanded the scope of dissociation along both pathological and nonpathological lines. In his 1906 book, *Dissociation of a Personality,* he described

[1]In the interest of space, I will focus on Janet as the starting point for dissociation. Although, we must keep in mind the relevance of prior work, especially in the fields of animal magnetism and spirit possession. Janet (1925), for example, credited the French magnetist Amand-Marie-Jacques de Chastenet, Marquis de Puységur's description of somnambulism as a precursor to his own theory of dissociation.

'Miss Beauchamp' as developing four personalities, building upon the complexities of the divisions in personality. Elsewhere, Prince (1929) described forms of 'absentmindedness' or 'abstraction', which could be roughly approximated to forms of 'spacing out' or a kind of 'loss of present awareness', as forms of nonpathological dissociation. Prince's work began to expand what was considered dissociation beyond what Janet initially intended.[2]

The late 20th century brought about a revitalized interest in dissociative phenomena in the form of multiple personality, experiments in hypnosis, and an increasing interest in altered states of consciousness. During this time, the conception of dissociation shifted from structural divisions of consciousness (from the time of Janet and Prince) to include phenomenal or experiential separations and disconnections. The move to include phenomenal disconnections was one of the factors that lead to the theorizing of the continuum model of dissociation, which resulted in a wide variety of nonpathological altered states of consciousness, such as daydreaming, trance-states, 'spacing-out', and fantasizing to be included as forms of dissociation. For some critics, this expansion of the range of dissociative phenomena was seen as problematic. Detractors such as Onno van der Hart and Martin Dorahy (2009) describe this diffusion as "conceptual drift" that renders dissociation as "ill-defined" with "almost any psychologically derived breakdown in integrated functioning" to be considered dissociation (p. 19). They also point out that a broad, inclusive definition of dissociation incorporates phenomena which exhibit no clear developmental pathway, adding to the complexity and ambiguity. Even those that support the more inclusive definition agree that the term is imprecise term and could benefit from conceptual clarity (Cardeña, 1994; Frankel, 1994; Spitzer, Barnow, Freyberger & Grabe, 2006). It is with reference to these concerns and objections that we can speak of a "motleyness problem." Therefore, a satisfying account of the range of dissociation would help make sense of, and delimit, the range of phenomena that are grouped under this heading.

II. The Ontological Problem

With the motleyness problem pertaining to the number of different phenomena called dissociation, a related challenge for dissociation theory is to identify *what* is being dissociated. The term 'dissociation' suggests some kind of division or sundering—but what exactly is the thing that is being divided? I shall refer to this as the *ontological problem* of dissociation, since it relates to the mode of unity, and hence the mode of being that makes dissociation a possibility in human psychology. Sorting

out what is being dissociated is important not only for conceptual clarity, but also in practical application, especially insofar as the therapeutic goal is to integrate or unify dissociated parts.

The classical dissociationists Janet and Prince conceived of both consciousness and personality as the underlying unity that was susceptible to dissociative division. Janet (1907) also referred to the emancipation of the "system of ideas and functions" which itself is ambiguous, but was likely more of a functional description of the dissociated parts he was observing (p. 332). A central assumption of these ontologies is the focus on privileging internal, psychological structures, and the divisions that occur to these psychological structures.

One of the most explicit representations of the heterogeneity of ontological commitments in dissociation theory can be found in the account of dissociation and dissociative disorders found in the Diagnostic and Statistical Manual of Mental Disorders, fifth-edition (DSM-V). The DSM-V defines dissociation as "the splitting off of clusters of mental contents from conscious awareness" (p. 820) and the "disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior (p. 291). Here, we see the DSM-V present a variety of ontological commitments for *what* is being dissociated. Moreover, terms such as 'consciousness', 'identity' and 'body representation'—to name a few—are difficult to define, have rich philosophical and psychological histories in their own right, and remain ambiguous, driving home the challenge to a cohesive and consistent account of dissociation. Implied in the DSM-V's description is the assumption that there exists a normal integration, which raises the question of how to determine what this normal integration of 'consciousness', 'memory', 'emotion' (and other terms on this lengthy list) actually looks like. Given this, a reasonable goal for a model of dissociation should be to provide an account of how these different dissociated parts come together. On this point the DSM-V's account is quite lacking.

III. The Normative Problem

According to Janet, any division in consciousness or personality should be considered pathological; so-called normal people do not exhibit these divisions. Moreover, these divisions are seen by Janet as the result of traumatic experiences. However, as mentioned earlier, Prince's project involved theorizing nonpathological forms of dissociation, a trend that continues today (Butler, 2006). This presents us with our third challenge: to distinguish normal from the pathological forms of dissociation, particularly in the context of trauma.

The current debate—really an updated version of Janet and Prince's positions—is whether dissociation should be classified along a dimensional continuum, incorporating phenomena ranging from normal/everyday experiences

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[2]Prince was not the only one to think along these lines. Other notable figures that also contributed to the expansion of dissociation included William James and Frederic Myers.

such as daydreaming as well as pathological forms, or whether it should be understood as a categorical, strictly pathological phenomenon. Probably most significant in the narrower categorical camp is the theory of *structural dissociation* (Steele, van der Hart, & Nijenhuis, 2009). This model depicts two parts of the personality, which includes the apparently normal part (ANP) and the emotional part (EP). A key part of this model is it has a single etiology—traumatic experiences. Structural dissociation theorists argue that only the pathological division of the personality in an ANP and EP should be called dissociation, and the others that are mapped onto the continuum (e.g., daydreaming, 'spacing-out', etc.) would be better labeled as 'alterations in consciousness'.

Of course, the DSM-V provides the general criterion "symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" to determine pathology in all dissociative phenomena. However, we must keep in mind that just because these dissociative experiences are defined in the DSM-V, this does not mean that they are necessarily pathological. The DSM-V excludes the diagnosis of DID if the 'symptoms' are "part of a broadly accepted cultural or religious practice" (p. 292). This provides evaluative latitude for determine pathological dissociation in the context of cultural practices. In fact, dissociation may take on an adaptive or therapeutic role, especially in response to trauma, as a way of "not knowing" harmful information (Barlow & Freyd, 2009). Even if the DSM's strategy of determining pathology is useful, distinguishing what might be adaptive or therapeutic from pathological is important. Moreover, the stigma that may accompany the designation of pathology, especially in the context of an adaptive response, is also a concern. The take-home message is that a theory of dissociation has to have the resources to adequately delineate among the normative and pathological, along with the nuanced distinction of the adaptive/therapeutic role.

IV. Concluding Remarks and Looking Ahead

The aim of this paper has been to articulate three problems that have been generated by the history of engagement with dissociative phenomena, and by its contemporary analysis. Taken collectively, these three problems help frame a challenge that a minimally adequate accounting of dissociation should meet. First, such an account should define the class of phenomena that are understood as dissociative and shed light on the unity that belongs to that class. Second, such an account should be clear about what thing or things exhibit division when dissociation is at work. Finally, such an account should help clinicians to make sense of the distinction among normal, pathological, and therapeutic instances of dissociation.

There exists an extensive body of theoretical and scientific literature that address dissociation, and this work may help to address these problems. But to date there is no clear consensus about how the three challenges can or should be met. Perhaps there may be value in looking beyond the current models and ontological commitments to find a reasonable solution to capturing the phenomenological richness and complexity of dissociation.

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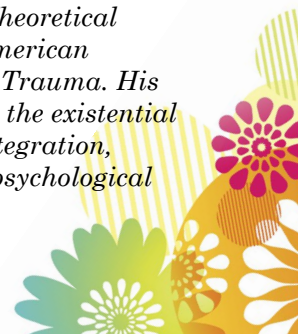
Dissociation in a Non-clinical Sample of Performing Artists and Athletes: A Review

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Performing artists and athletes are generally regarded as highly skilled and disciplined. In order to achieve professional / elite level performance, they must dedicate long hours to attain expertise in their field. To manage these demands, many performers and athletes employ dissociative processing, both within the normative and pathological range (Thomson, Keehn, & Gumpel, 2009; Thomson, Kibarska, & Jaque, 2011). Our laboratory mission is to address the reality that minimal attention is given to the investigation of trauma exposure and dissociation in these populations (Leahy, Pretty, & Tenebaum, 2008; Swart, van Niekerk, & Hartman, 2010). Generally, research in sport and performance psychology tends to focus more on performance anxiety, injury rates, and protocols to optimize performance (Swart et al., 2010). This review will present findings that reveal a significant proportion of performers and athletes struggle with pathological dissociation, high trauma exposure, and toxic levels of shame, despite the fact that they continue to perform and compete at high levels.

Dissociation is often regarded as operating on a continuum, with many individuals experiencing everyday dissociative absorption such as getting lost in a task, daydreaming, or entering brief trance-like states; this may occur while driving or engaging in mundane repetitive activities (Butler, 2006). A smaller percentage experience dissociative states that disrupt functioning, including a sense of a continuous self; these states are regarded as pathological and are no longer operating in the normative range of the continuum (Allen, Filtz, Huntoon, & Brethour, 2002; Waller, Putnam, & Carlson, 1996). Dissociation is also a multidimensional construct (Briere, Weathers, & Runtz, 2005), which includes compartmentalization, depersonalization, disengagement, and identity and / or memory confusion. Examining dissociation in populations that achieve elite level expertise requires inclusion of these multidimensional dissociative processes, as well as differentiating normative from pathological experiences.

In sport psychology, dissociation and association are regarded as opposite ends of a spectrum; dissociative processing removes attention from the task, whereas association directs attention towards the task (Masters & Ogles, 1998). Optimal dissociative engagement is described as the ability to distract from pain while training (Masters & Ogles, 1998). Athletes learn to compartmentalize their pain and detach from their emotional responses in order to increase skill competency. However, when dissociation is employed during competition the performance results tend to be poor (Tenenbaum & Connolly, 2008). Within a sport culture, dissociation is encouraged as a training strategy and discouraged during competition (Hutchinson & Tenenbaum, 2007). Unfortunately, for many athletes and performers this dissociative strategy may lead to increased injury and body objectification. This was found in a study that examined elite international rhythmic gymnasts and professional dancers (Thomson, Kibarska, & Jaque, 2011). The athletes endorsed extremely high dissociative abilities to ignore pain and the professional dancers identified prolonged periods of feeling that their body did not belong to them.

Unlike the field of sport psychology, performance psychology is currently in the early stages of development. Studies in this field generally investigate dissociation as a multidimensional and pathological process. For example, in a study that examined actors compared to non-actors, there was a higher prevalence of actors (32% of the actor sample compared to 23% of control participants) who claimed clinical levels of dissociation (as measured by the Dissociative Experience Scale-II Taxon subscale [DES-T], with a cut off score of 25 on the taxon scale). In this study, there were significant mean differences between the two groups (actors DES-T mean = 29.31 [sd = 7.08] compared to control DES-T mean = 21.19 [sd = 8.34] with a significance level ≤ .01); the actors readily identified a disruption in their sense of a continuous self (Thomson & Jaque, 2011). Other studies suggest that actors struggle with boundary blurring of self and other and have more difficulty with identity formation, in particular, when they are actively rehearsing or performing a character (Burgoyne, Poulin, & Rearden, 1999; Hannah, Domino, Hanson, & Hannah, 1994). In a study that examined musicians, higher dissociative processing was identified as a factor that diminished memory retention as well as decreasing their ability to perform at optimal levels (Swart et al., 2010). Another investigation compared dissociative processing in two groups, the generators of the arts (choreographers,

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directors, composers, and playwrights) and the interpreters of the arts (actors, dancers, singers, musicians); the interpreters experienced more intense dissociative processing, especially absorption and depersonalization (Thomson, Keehn, & Gumpel, 2009).

Identifying performers and athletes with pathological dissociation enables researchers to compare individuals with and without dissociative pathology. Findings suggest that performers and athletes who endorse pathological levels of dissociation are less able to enter high flow states (optimal performance) (Thomson & Jaque, 2012a). Specifically, they are less able to focus on the task at hand, receive unambiguous performance feedback, and sustain a sense of control. Their ability to match their skill level to meet the performance or athletic challenge is compromised; they remain highly self-conscious, which interferes with the immediacy of their responses to internal and external stimuli (Thomson & Jaque, 2012a). Likewise, findings indicated that individuals who suffered clinical levels of depersonalization (high intensity, frequency, and duration) were less able to achieve flow states. Highly depersonalized performers were also more anxious and employed more emotion-oriented coping strategies under stress (Thomson & Jaque, 2018). In general, performers who experienced depersonalization were less likely to achieve optimal performance and expressed more emotional distress than those who did not.

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Examining childhood adversity exposure and the effects of cumulative trauma in performer and athlete samples also reveals strong associations between trauma and dissociation. For example, in a study that investigated PTSD and dissociation in dancers, dissociation was even more intensely present in dancers with a diagnosis of PTSD (20.2% had PTSD) (Thomson & Jaque, 2015a). In a study that examined athletes, those who were exposed to childhood maltreatment also displayed increased dissociation (Leahy et al., 2008). Investigations that identify performers and athletes with a classification of unresolved mourning (as determined by the Adult Attachment Interview assessment), demonstrated that pathological dissociation was higher in those classified with unresolved mourning (Thomson & Jaque, 2012b). Sadly, a higher prevalence of unresolved mourning was found in performing artists compared to athletes and healthy control samples (Thomson & Jaque, 2018a). Further, actors (30.8%) experienced a higher rate of unresolved mourning and dissociation compared to dancers (16.7%), athletes (17.4%), and a non-clinical active control sample (28.6%) (Thomson & Jaque, 2011, 2012c, 2018a).

Research findings also demonstrated that elevated dissociation in performers and athletes was associated with heightened shame (Thomson & Jaque, 2013). Many performers and athletes are at increased risk for intense shaming experiences during training and performing/competing. Repeated shaming experiences may become toxic, which reinforces an internalized belief that the self is deeply flawed and unworthy (Eusanio, Thomson, & Jaque, 2014; Thomson & Jaque, 2013). Likewise, shame that is internalized in response to exposure to childhood traumatic events further intensifies dissociation (Dorahy, 2010) and also significantly compromises optimal performance (Thomson & Jaque, 2015). Unfortunately, childhood trauma, including sexual abuse, is often under-reported in sport and performing arts settings (Leahy et al., 2008). Performers and athletes with a history of childhood adversity, cumulative trauma experiences, and exposure to shaming events tend to have more intense dissociative processing; they may employ dissociation to thwart painful emotions and compartmentalize traumatic memories. Study investigations indicate that many performers and athletes are unable to disclose these experiences despite heightened suicidal ideation (Thomson & Jaque, 2015a). They are well practiced at dissociating pain during training and they may employ this coping strategy when interacting with health care professionals, coaches, and other performers (Leahy et al., 2015; Thomson & Jaque, 2015a).

Study findings indicate that approximately 17 – 30% of performers and athletes (Thomson & Jaque, 2012) exhibit pathological levels of dissociation; greater awareness of this prevalence rate may influence subsequent research. Studies should include the moderating and mediating effects of dissociation on other performance-related disorders, in particular, eating disorders, self-injurious behaviors, substance use, anxiety, depression, and musculoskeletal injuries. Although these elite performers derive meaning from their chosen artistic or sport domain (Thomson & Jaque, 2018b), their level of performance is often compromised. Unfortunately, the cultures of sport and the performing arts encourage non-disclosure of psychological or physical illnesses or injuries (Barker, Soklaridis, Waters, Her, & Cassidy, 2009). Many elite performers, and those who work with them, may misconstrue pathological dissociative processing as poor concentration, disinterest, burnout, or lack of motivation in the athlete or performer. For example, one world-class rhythmic gymnast in our research study expressed great frustration that her dissociative disorder remained undiagnosed throughout her career. Only later did she
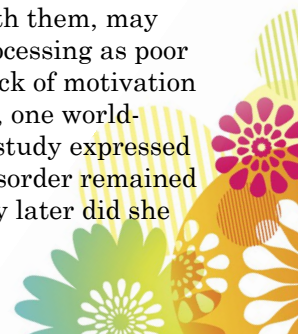
discover that her flawed competitive performances were directly related to severe depersonalization. Sadly, many performers, coaches, and medical practitioners do not understand the nature of dissociation in these elite populations; they may also lack awareness that performers and athletes with pathological dissociation may need to continue to perform or compete in order to bolster wellbeing and enhance purpose and meaning (Thomson & Jaque, 2018b; Wilhelm, Kovess, Rios-Seidel, & Finch, 2004).

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The Development of a Validity Scale for the Dissociative Experience Scale (DES)

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Malingering is an issue that most, if not all, professionals in the mental health field will encounter. For various reasons, clients present with symptoms that may be overstated, exaggerating symptom complexity or severity, just as an individual wishing stronger dosages of a medication might exaggerate physical or mental pain. Conversely, they may try to minimize symptoms, understating their level of distress to protect their own or another's self-image, as an individual interested in gaining custody might downplay their own or their children's pathology. Individuals who complete trauma self-reports, a typical method for assessing trauma, may distort their reports in a way that casts them in a more or a less favorable light, depending on the desired outcome (Berry, 2000). It is the responsibility of the mental health professional to review the information provided and utilize validity scales when available to ensure that the data they collect are reliable. In addition, it is important to understand how a trauma history may increase the likelihood of some validity scales being elevated. Psychologists and psychiatrists agree that assessing malingering is a critical aspect of clinical evaluation, particularly in forensic evaluation (Paulson, Straus, Bull, MacArthur, DeLorme, & Dalenberg, 2018).

Malingering consists of a purposeful attempt by an individual to exaggerate symptoms, or fake diagnoses in order to obtain personal gain (American Psychiatric Association, 2013). There are various reasons that individuals may malinger, including attempts to win civil compensation or disability, or efforts to avoid criminal responsibility (Weiss & Van Dell, 2017). Validity scales can provide some data about the possibility of malingering stemming from any of these sources; however, it is critical to note that one scale cannot be considered sufficient to determine someone is engaging in malingering.

Although "malingering" is the more common term for intentionally inaccurate responding (used in more than 1600 publications in PsycINFO in the last decade), some argue that "feigning" would be a more accurate term. In many cases, there is no way to determine whether external incentive is the reason behind a given inaccurate response, which Rogers (2018) argues should be a prerequisite for the use of the term malingering. Although early uses of the word malinger did refer to soldiers who were feigning illness to shirk duty, the term is now used more broadly. Malingering is part of the nomenclature of many of the more common scales and tests designed to detect purposeful inaccuracy, such as the Test of Memory Malingering, the Malingering Probability Scale, or the Structured Inventory of Malingered Symptomatology. Although there are meaningful differences between individuals who are feigning symptoms as a cry for help and those exaggerating for external incentive, we will use the term malingering in order to match the most common usage.

Malingering and Dissociation

Malingering is often a reported source of concern to those administering the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1993). The DES and its variants (e.g., DES-II, DES-C) are among the more commonly administered screeners for pathological dissociation. Research utilizing the DES is widespread, with over 2,200 hits on PsycINFO alone, thus lending credence to the notion that dissociation in both psychopathological and normative populations is predictive of a variety of important outcomes. Dissociation as a symptom of exposure to trauma (as underlined in the development of the Dissociative subtype of posttraumatic stress disorder [PTSD]), and as a central symptom in the more controversial trauma-related syndromes and disorders (e.g., Dissociative Identity Disorder) has led to the use of the DES in forensic settings, where those being tested may have incentive to over-report dissociative symptoms. Thus, the lack of a validity scale in the DES is a problem for those attempting to make use of the scale in research, forensic, and clinical settings

In research, use of the DES in online surveys may be especially problematic in the absence of a reliable validity scale. One of the major challenges in administering the DES (or any other self-report measure) online is that respondents, in order to maximize payments for the number of surveys

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completed, try to complete online forms quickly, use "bots" to answer the questions, or lower the standards for accurate reporting, thus reducing the fidelity of responses. In addition, individuals who do not have an adequate level of English proficiency can complete online assessments without having a clear understanding of the questions (a problem not specific to the DES, but relevant to online survey use in general). These factors, among others, have enhanced the need for a DES validity scale in recent years, as "big data" questions are posed online by trauma researchers.

In creating a validity scale for the DES, we incorporated several approaches frequently used when evaluating validity:

Inconsistency. This method requires a specific construct to be assessed several times during the assessment to determine agreement. Six items were developed for the DES that directly contradicted statement posed in the original test. For instance, the item "Even if I am watching television, it is very easy to get my attention" was designed to be negatively correlated with affirming a frequent experience of watching television or a movie and becoming so absorbed in the story that they were unaware of other events happening around them. A score from 0-6 was calculated for number of paired strong agreements.

Atypicality. Atypical questions are items that describe extremely rare symptoms that are known to be uncommon to the target population. These questions appear plausible to those attempting to malingering these symptoms. Six atypical items were developed by the Trauma Research Institute team for the DES and verified by three highly published authors on dissociation (e.g., some people find that when they think about the trauma they faint or have a headache).

Distorted Structure. This method involves observing a pattern in an individual's full set of DES responses that is unusual or uncommon in dissociative individuals. Here we took advantage of the relationship between the known high base rate items of the DES (absorption items) and the known low base rate items (taxon items) indicating more serious or pathological forms of dissociation. Taxon scores at or above the level of absorption score, indicating elevation in more serious

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symptoms without an elevation in more common symptoms, thus are suspect.

Unlikely Completion Time. By asking a group of PhD students to complete our survey and recording their completion times, we established a cutoff for time to completion that may indicate insufficient care in answering the questionnaire. To measure the validity of responses, participants who completed the survey one standard deviation faster than our PhD group were considered to have put forth less effort than required for this assessment.

English fluency. We tested for English proficiency in these online surveys to evaluate likelihood that participants were able to understand the instructions and answer the survey accordingly. An 8th grade reading level vocabulary test was used according to the Spache Readability Formula. Respondents who received scores under 60% on the vocabulary test were considered potentially invalid. Those who had internet protocol (IP) addresses that indicated residency in non-English speaking countries, were eliminated from the respondent pool.

In our initial study, we examined participants within four groups. A PTSD group ($n = 30$) was asked to complete the survey and answer the questions honestly. A second online community sample, recruited through Amazon MTurk, also was asked to answer the survey honestly ($n = 66$). An additional press for accuracy was included by stating that "giving dishonest answers on a medical survey is like giving contaminated blood in a blood donation. It can be extremely harmful for the scientific project." In prior trauma work in our lab, when trauma status was known, this statement has been shown to enhance accuracy in our community samples. Participants in the malingering group ($n = 59$) were asked to pretend to be someone with dissociative symptoms and malinger on this survey. They were provided a brief description of dissociation. An additional monetary incentive of five dollars was offered to the best malingerers. Lastly, participants in the "careless" group ($n = 93$) were asked to treat this task as they would if they were making a living from answering these surveys, completing the survey as fast as they could while maintaining accuracy. After all participants
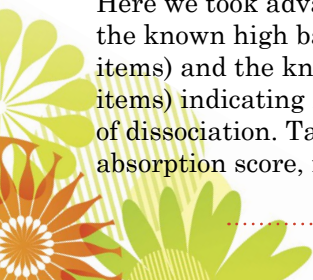
were given their respective instructions, a multiple choice question assessed whether the participant was able to identify their instruction set.

In our first draft of this validity scale, preliminary findings revealed that differentiation between the groups was possible using Atypicality, Inconsistency, Distorted Structure, and Unlikely Completion Time. The four groups significantly differed on endorsement of atypical items, with the malingering group differing from the other groups. The forced malingering group had a higher inconsistency mean and a smaller difference between the taxon and absorption items than did the two honest groups, with the careless group scoring between the honest and malingering samples. Importantly, the PTSD group, who received a score on the DES well above the normative mean, had a false positive rate (falsely indicating that the individual was malingering) under 10%. A logistic regression was able to correctly classify 84.8% of the honest participants and 62.7% of the known malingerers. In the final publication version, we intend to double the sample size and refine the atypical and inconsistency items. We are pleased with the initial success of the scale, and hope that it will be of value to other researchers and clinical evaluators. We would also like to note, however, that the DES is a screening tool for dissociative symptoms, and would not be a definitive diagnostic tool for identifying dissociative disorders with or without our added validity indicators. Ideally, if malingering is suspected after use of our methods, further malingering assessment would investigate varying reasons for the likely inaccurate responding (e.g., the Test of Memory Malingering, the Structured Inventory of Malingered Symptomatology).

Summary and Conclusions

Malingering is an issue across many fields of psychological research, yet it is unclear how often malingering is actually assessed when conducting online research. A recent search of PsycINFO yielded 1,278 hits for the combined search terms of "MTurk, Mechanical Turk, or Qualtrics," most in the last 5 years, suggesting the importance of question. In 50 randomly chosen MTurk survey studies, 28 included no malingering or accuracy assessment at all, with 4 more using only checks for repeated IP addresses. Most of the remaining studies either used at least one test with an existing validity scale, or embedded consistency or attention measures. We suggest that our general method might be used to address inaccuracy issues in many online survey areas.

An additional consideration that emerged in the course of this study was the prevalence of suspect IP addresses. For researchers who wish to limit their sample to U.S. citizens or residents and/or to native English speakers, the presence of non-U.S. IP addresses among survey respondents should be concerning. A check of IP addresses should be a standard practice during data cleaning. In our initial MTurk sample, 14% of the respondents had IP addresses from non-English speakers countries, with over 50% of this subgroup failing one or more of the malingering or inaccuracy screens. An additional 8% did not pass the English vocabulary test.

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We recommend that researchers review the assessments they use and ensure that a validity/malingering check is a part of their procedures or, in the absence of a developed scale, include one or more of the procedures noted here. Appending such a subscale to online assessment batteries is easy and efficient (that is, adds very little time to the assessment) and may partially protect the research effort from careless respondents, purposely inaccurate respondents, and bots. Additionally, a standard component of data cleaning should include an assessment of the IP addresses of all participants, potentially eliminating subjects if their address raises concerns over citizenship, residency, language ability, or other related issues. The DES would benefit from an embedded validity scale given its rate of use and clinical utility when assessing dissociative symptoms. As it stands, there is no scale within the DES that would reliably indicate instances of overreporting dissociative symptoms, leaving it vulnerable to symptom exaggeration, especially with the advancement of administering assessment measures online. Inclusion of an embedded validity scale would be an asset, and could potentially provide for greater clinical utility of the DES.

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What the Research Says about the Treatment of Patients with Dissociative Disorders—and an Invitation to Work and Learn Together with the TOP DD Research Team

Hugo Schielke, PhD; Amie Myrick, MS, LCPC, & Bethany Brand, PhD
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Persons who meet criteria for dissociative disorders (DDs) often experience high levels of chronic impairment across multiple domains of functioning, including complex psychiatric symptoms as well as social, emotional, and physical health difficulties (e.g., Brand et al. 2009a, Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006; Sar, Akyuz, & Dogan, 2007). Such challenges result in marked suffering and significant treatment costs. Patients with dissociative identity disorder (DID), the most complex DD, suffer from significant rates of psychiatric comorbidity, including depression, posttraumatic stress disorder (PTSD), anxiety disorders, borderline personality disorder (BPD), substance use, disordered eating, somatic symptom disorders, and high rates of non-suicidal self-injury (NSSI) and suicide attempts (Boon & Draijer, 1993; Brand et al., 2009a; Ellason, Ross, & Fuchs, 1996; Foote, Smolin, Neft, & Lipschitz, 2008; Leonard, Brann, & Tiller, 2005; Lipsanen et al., 2004; McDowell, Levin, & Nunes, 1999; Middleton & Butler, 1998; Rodewald et al., 2011; Şar et al., 2003; Webermann, Myrick, Taylor, Chasson, & Brand, 2016). Patients with DDs have been found to attempt suicide more often than patients with PTSD, substance use disorders, or BPD without a comorbid DD (Foote et al., 2008), and to demonstrate 50% higher average impairment than patients with other disorders (Johnson, Cohen, Kasena, & Brook, 2006). The severity of DD patients' symptoms often requires repeated and costly treatment within more restrictive levels of care (Mueller-Pfeiffer et al., 2012).

Effective treatment for DDs can reduce symptoms and suffering (e.g., Brand et al., 2009a, 2009b, 2013, 2019) and decrease health care costs for patients and society-at-large (Lloyd, 2016; Myrick, Webermann, Langeland, Putnam, & Brand, 2017). Unfortunately, DD patients average 5–12.4 years in treatment before being correctly diagnosed (Spiegel et al., 2011). During those years, they typically experience significant psychiatric and emotional distress, may need costly tests, medical procedures, and lengthy psychiatric hospitalizations, and/or may attempt (or complete) suicide.

Factors Leading to Under-diagnosis and -treatment

Few professionals receive adequate training in the assessment or treatment of dissociation (Cook, Simiola, Ellis, & Thompson, 2017; Courtois & Gold, 2009; Gleaves, 2007), and the information presented in psychology textbooks to future mental health professionals is often incomplete or inaccurate (e.g., Wilgus, Packer, Lile-King, Miller-Perrin, & Brand, 2015). Further, this information may include myths, which persist despite lack of scientific evidence as well as evidence to the contrary in studies with DD samples (for overviews, see Brand, Şar, et al., 2016; Dalenberg et al., 2012). Given the paucity of evidence-consistent training, it is understandable that clinicians demonstrate difficulty diagnosing DDs when presented with vignettes that clearly describe symptoms that fulfill DD criteria (Dorahy et al., 2017) and discriminating DDs from disorders with symptom similarities (e.g., BPD and schizophrenia; Welburn et al., 2003). This lack of training also results in a relative paucity of appropriate treatment options for patients diagnosed with DDs. For discussions regarding differential diagnosis and treatment, see Brand and Loewenstein (2010) and Loewenstein, Frewen, and Lewis-Fernández (2017). For discussions of DD assessment, see Brand, Armstrong, and Loewenstein (2006) and Brand, Schielke, Brams, and DiComo (2017).

Research indicates that when patients engage in treatment consistent with expert consensus recommendations, they show reductions in symptoms, emotional and behavioral dysregulation, distress, suicide attempts, NSSI, and psychiatric hospitalizations (e.g., Brand et al., 2009 a, 2009b, 2013, 2019; Jepsen, Bad, Langeland, Sexton, & Heir, 2014; Lampe, Hofmann, Gast, Reddemann, & Schüßler, 2014; Rosenkranz & Muller, 2011), and patients who remain in treatment generally show improvement across domains of functioning (e.g., Coons & Bowman, 2001; Ellason & Ross, 1997; Jepsen et al., 2014; Kluft, 1984/1985; Lampe et al., 2014) that are maintained over time (Ellason & Ross, 1997; Jepsen, Langeland, & Heir, 2013).

Current Treatment Guidelines and Recommendations

The complex trauma literature (e.g., Chu, 2011; Herman, 1997; Kluft, 1993a) and International Society for the Study of Trauma and Dissociation (ISSTD) expert guidelines for the treatment of DID (2011) recommend a three-stage treatment model that prioritizes stabilization and safety throughout. The first stage is present-centered and explicitly focused on *stabilization and safety*, emphasizing psychoeducation about trauma-related symptoms, grounding techniques, containment imagery, and other healthy coping skills aimed at

reducing emotional dysregulation, PTSD symptoms, and dissociation. The first stage also focuses on replacing unhealthy tension-reduction behaviors (e.g., NSSI, substance abuse, disordered eating) with recovery-focused behaviors and the development and maintenance of a collaborative therapeutic alliance (e.g., Briere & Scott, 2015; Courtois & Ford, 2013; Steele, Boon, & Van Der Hart, 2016). In DID patients, stage one work also involves working towards improved communication and cooperation between dissociative self-states (Brand, 2001; Brand et al., 2012; Loewenstein, 2006). Once stabilized, patients may move into the second stage of treatment, *trauma processing,* which involves developing a narrative of non-traumatic and traumatic experiences, resolving trauma-related cognitive distortions, and processing trauma-related memories in a carefully paced manner (e.g., Kluft, 1999) while maintaining an emphasis on safety, grounding, and containment (e.g., Kluft, 1993b). The third and final stage focuses on *reconnecting* with oneself and others and progressing towards personal life goals.

The Treatment of Patients with Dissociative Disorders (TOP DD) Studies

The TOP DD research program is currently focused on developing cost effective and easily accessible education programs that teach DD patients and therapists about interventions that address DD patients' significant symptoms, suffering, impairment, and treatment costs. Some of the most crucial TOP DD findings to date are presented below; see TOPDDstudy.com for additional studies and more information.

The Naturalistic TOP DD Study

The first TOP DD study, a prospective, naturalistic study of DD treatment outcomes, was designed to address some of the methodological limitations of previous studies examining trauma-related disorders, including small sample sizes and participation criteria that typically excluded DD patients (e.g., dissociation, co-morbidity, substance use, NSSI, suicidality; see Brand et al., 2009b, for a review). The naturalistic TOP DD study followed the outpatient work of over 290 international therapist-patient pairs and remains the largest outcome study conducted with DD patients to date. Over 30 months, therapists and patients reported decreases in the patients' dissociative, PTSD, and general psychiatric symptoms; decreased NSSI, suicide attempts, hospitalizations, and treatment costs; and increases in adaptive functioning (Brand et al., 2013). A six-year follow-up found these patients continuing to benefit from expert guideline-informed treatment (Myrick et al., 2017).

The Expert Survey

A panel of thirty-six expert DD clinicians from North America, Europe, and Australia shared how often they make use of 26 core DD treatment interventions in each of the stages of DD treatment (Brand et al., 2012). The DD experts emphasized a core group of interventions focused on: safety and stabilization; psychoeducation regarding affect regulation skills (e.g., grounding and containment) and self-care; ego strengthening; awareness of emotions and body sensations; impulse control; development of healthy relationships; and the creation and maintenance of the therapeutic alliance.

A Comparison of Interventions Used by Clinicians Compared to Experts' Recommendations

A comparison of the interventions reported by non-expert therapists in the TOP DD naturalistic study with those recommended in the expert survey (Myrick et al., 2015) indicated that non-expert therapists reported less frequent focus on "establishing safety; stabilizing from stressors and crises; teaching and practicing self-care, containment, grounding, affect tolerance and impulse control; educating about disorders and treatment; relationally focused interventions; and processing when and why dissociation occurs" (pg. 62-63). These findings informed the development of the TOP DD Network psychoeducation program for DD patients and their therapists.

The TOP DD Network Study

In an effort to provide easily accessible education about interventions that help stabilize early-stage DD patients to DD patients and their therapists, the TOP DD team developed a 40-session, 24-month Internet-based psychoeducation program consistent with expert recommendations and ISSTD treatment guidelines addressing DD patients' symptoms, affect regulation difficulties, and struggles with maintaining safety. Information was presented by video and accompanied by exercises aimed at helping patients put the information into practice. Participants could re-review sessions as often as they wished; to allow time for application and practice, however, participants had to wait 7 days before gaining access to new sessions. Participation was associated with decreased symptoms, higher adaptive capacities, and improved emotion regulation (overall sample $|d|$s = 0.44–0.90), and NSSI (Brand et al., 2019). Notably, patients with higher initial levels of dissociation – the patients often described as the most difficult to help progress in treatment, and the patients for whom this program was specifically developed – demonstrated the greatest improvements over the course of the program ($|d|$s = 0.54–1.04 vs. $|d|$s = 0.24–0.75 for patients with lower initial levels of dissociation). The reduction in NSSI in the patients who entered the program with the highest levels of self-injury was particularly striking: the three patients with the highest reported incidences of NSSI at program entry (approximately 100, 125, and 150 times in the previous 6 months) had considerably reduced their NSSI by the end of the program (respectively self-injuring 0, 10, and 10

times in the previous 6 months) – a notable finding given that patients with high NSSI are often excluded from clinical research.

Future Directions

The TOP DD naturalistic study demonstrated the benefit associated with treatment that focused on trauma and dissociation for those diagnosed with DDs. However, community clinicians appear to under-utilize some DD treatment interventions DD experts think are critical for stabilizing DD patients. The TOP DD Network program aimed to share education based on expert recommendations with patients and their therapists in order to assist in stabilizing DD patients.

The TOP DD motto is "work together, learn together" – and in keeping with this, the next TOP DD study will evaluate a participant-informed revision of the Network program within a randomized controlled trial (RCT) design. The TOP DD Network psychoeducation programs intend to demonstrate expert-recommended and evidence-informed stabilization-focused interventions to DD patients and therapists in a sequence we recommend based on research findings to date, the feedback of our participants, and our years of experience treating DD patients. We hope many of you will work and learn together with us by participating in the Network RCT – and invite you to visit TOPDDstudy.com to find out more!

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"It's Just a Donut"
Working with Chronically Dysregulated Parts in a Client with Dissociative Identity Disorder: A Case Study

Lynne H. Harris, MA, MPH, LMHC, LPC

It's "just a donut" became an unlikely catchphrase for my work with a client who has Dissociative Identity Disorder (DID). It started in the retelling of a routine, but fraught, Dunkin Donuts run and ended up as a way we use to signal the patient's amygdala to turn off when it is not truly necessary.

I approach working with patients living with dissociation using a combination of Sensorimotor Psychotherapy, Eye Movement Desensitization and Reprocessing (EMDR), and ego state or parts therapy, which is grounded in Herman's (1992) staged approach to trauma recovery. Our primary goal for the first two years has focused on overcoming chronic dysregulation in the central nervous system. I have provided psychoeducation about the Window of Tolerance (Siegel, 1999), and how trauma memory is stored differently than normal narrative memory because the parts of our brain responsible for placing a date and time stamp (hippocampus) on sensory input from the thalamus, and helping place it in a context (frontal cortex) go off line during trauma to help increase rate of reaction to a life threatening, or perceived life threatening, circumstance. I normalized how once a traumatic event happens, our brain in part stays alert to the possibility it can happen again, even while another part of the brain carries on with life—often with little or no memory of the event, thanks to our brain's ability to compartmentalize. With complex trauma and DID, I often see a highly sensitized nervous system adapted to an unsafe world, ready to speed up or shut down with slight provocation. Using the Structural Dissociation theory (Van der Hart, Nijenhuis, & Steele, 2006), I helped her understand how parts of the personality split along the lines of action systems for socialization/procreation and defense.

To demonstrate this approach, I will present my work with Ms. X, who is a 43-year-old Caucasian woman who experienced extensive neglect, as well as emotional, physical, psychological abuse by her parents in a strictly religious family with nine siblings. She was raped by an older brother as a child. She left home in her later teenage years and married a man, 17 years her senior, who encouraged her to work as a stripper. It was after working one night in a strip club that she was

Lynne H. Harris

kidnapped, held for 24 hours in a house, and repeatedly raped by three men when she was 19 years old. She barely survived.

When she first entered therapy, she had just been discharged earlier in the week from a 53-day inpatient treatment stay for alcohol use and suicidality. She reported having a history of alcohol use for 20 years, with a pattern of daily drinking one pint of vodka per day prior to hospitalization, and binge eating. She told me she had been "Baker-acted" three times in the past two years. She was attending SMART recovery and returning to work full time at the outset of therapy. She reported having a trauma history since childhood with repeated, life threatening experiences. In response to the question on the intake questionnaire about what was bringing her to counseling at that time she wrote: "I have survived a kidnapping and brutal rape of three men who left me for dead in 1995. Sexual abuse by ex-husband, child hood trauma".

At the intake session, I saw signs of dissociation as we were talking. I was aware that she had not been previously diagnosed with a dissociative disorder. At first, my calling attention to the abrupt changes in her affect that accompanied switches among parts caused a negative response, indicating a need to slowly acclimate her to parts work. Much later she told me she "always knew" the parts were there and that it was weird for someone else to see it. It took her a while to get comfortable acknowledging their presence and even more time before we could study the parts of herself and how they function to help, as all parts are formed to help in some way.

One of the hardest aspects of working with adults with DID is that the present day self is often "missing in action" (Fisher, 2017). That leaves other parts to do the work of navigating day-to-day life, often with poor results. For Ms. X, a fearful child part would take over at times but be in the body of a 43-year-old adult with a job, an adult committed relationship, and two children, one with special needs. We were able to identify a seven-year-old part, a 13-year-old part, a 19-year-old part, a 23-year-old part, and a 26-year-old part, all of whom often were "in the front" and who often stepped in, especially when there was any anticipated conflict (e.g.,

a disagreement with her partner, or a performance issue at work). At one point, we established that she did not actually know her current adult self, and that that part appeared to be weaker, more transient, and often would go into "ostrich" mode to avoid challenging or difficult life situations. We were able to eventually observe the pattern where the adult self was hiding out, not wanting to see, and other more assertive or aggressive parts would feel the absence of the adult self and take over out of necessity.

Therapy then shifted to helping Ms. X increase her felt sense of the adult self, who we referred to by age, so she would know when she was present, and to strengthen this adult part so she could remain present at all times. In essence, we shifted the relationship between the wise, adult, 43-year-old self and other parts so it worked more like an alliance in which she could hear and accept help from other parts that could be resources (e.g., "26" could lend her confidence and assertiveness) to the adult, but without loss of conscious connection to the present moment. We have worked together for over two years.

The story of "it's just a donut" is as follows. On a routine weekend my client went to Dunkin Donuts to get breakfast treats, as is the custom of her and her son. They always got her partner his favorite - cake donuts but with chocolate frosting on them - which is not a standard offering, and would have to be made special at her request. Every week it was the same order. One day she placed the order and the person behind the counter told her they could not make that, period. My client described that her immediate reaction was one of utter terror in her body, heart rate racing, could not talk, dissociated on the spot. She went home in what she described as a state of terror and fear and it took into the next day to calm it down. She reported this to me in our session almost a week later. We mindfully studied the body response evoked in the session by her retelling of the events, and focused on noticing the hyperarousal in her CNS as "just sensation" without attending to the contents of any thoughts or distorted cognitive schemas that were attached to it (e.g., I'm going to die, I'm in trouble, something bad is going to happen).   While noticing the sensation of fear in her body, I asked her to locate where she felt it the most (in her chest) and somatically resourced that part of her body by asking if it felt ok to put a hand to chest where she felt it. I asked her to try to notice if the *intensity* of the feeling fit the situation at hand ("just you and me talking in my boring office"), or if it was a better fit for something that may have happened another time. My client was able to identify it was more congruent with past situations. I reframed it as a "body memory" or "sensory memory", a form of a flashback. Then I encouraged her to cognitively explore what the *actual* consequence might be when she came home without the preferred donut. We discussed how, in the donut situation, the worst case scenario

was that her partner might be disappointed, or possibly angry, or that she was frustrated with the Dunkin Donut staff, but, I pointed out, none of those possibilities were life or death situations, and yet that is what her body was signaling to her. "It is just a donut", I said, "It is not life or death", "we are just in my office, talking". She looked at me, clearly back in her adult self and back in the room and laughed out loud and repeated, "It's just a donut! It's not life or death!" We repeated it laughing. And then we joked about how we should make t-shirts with the phrase printed on it. She creatively came up with other design ideas that reflect having a highly sensitized, overactive amygdala due to repeated trauma. She later actually drew these up and showed me.

So now, when she feels the old sensation of fear escalate in her body when we are working on something that triggers the CNS defensive response, she recognizes it, puts a hand on her chest and one on her belly and says, "This is fear. This is where it lives. It's not in my big toe". I sometimes do it with her. I place a hand on my chest and one on my belly. Together we say "It's just a donut. Nothing is happening now." Sometimes, I ask her to notice specific objects in the room to help reorient and reground. A favorite is to guess the stylistic era of the fabric on the couches (we think late 80's, early 90's). We somatically track the reduction of nervous system arousal as the re-orientation to safety in the present moment allows the amygdala to turn off and nervous system to return to baseline functioning.

I am happy to report that she continues to recover from a lifetime of trauma and is engaged, successful in her job, and has developed a group of women friends with whom she golfs every Friday after we meet.

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Worlds Apart: Dissociation and Traumatic Temporality

Robert D. Stolorow, Ph.D.

Coined by Pierre Janet in his investigations of hysteria, the term *dissociation* has taken on a variety of not-always-compatible meanings and usages in contemporary psychoanalytic theory and practice. Donnel Stern (1997), for example, defines dissociation as a "refusal to interpret" (p. xii) experience, a defensive "avoidance of verbal [symbolic] articulation" (p. 114)—a formulation that, interestingly, comes very close to the way Atwood and I (Stolorow and Atwood, 1992) conceive of the process of repression. Bromberg (2003), in contrast, views dissociation as "a defense against trauma … [that] reduces what is in front of someone's eyes to a narrow band of perceptual reality…. Its key quality is its ability to retain the adaptational protection afforded by the hypnoid separateness of incompatible self-states, so that each can continue to play its own role, unimpeded by awareness of the others" (p. 561). Bromberg's conception of dissociation bears a similarity to Kohut's (1971) description of a "vertical split in the psyche" (p. 176). Like Bromberg, I think of defensive dissociation phenomenologically as a kind of "tunnel vision"—a narrowing of one's experiential horizons so as to exclude the terrifying, the prohibited, and the emotionally unbearable. Unlike Bromberg, however, I would emphasize the keeping apart not just of incompatible self-states but, more broadly, of incommensurable emotional worlds. I have sought to rethink the concept of dissociation in terms of the devastating impact of emotional trauma on our experience of temporality.[1] Dissociation, I have tried to show, is traumatic temporality, and traumatic temporality is the condition for the possibility of the defensive use of dissociation (Stolorow, 2011).

Trauma devastatingly disrupts the ordinary, average-everyday linearity and unity of temporality, the sense of stretching-along from the past to an open future. Experiences of emotional trauma become freeze-framed into an eternal present in which one remains forever trapped, or to which one is condemned to be perpetually returned by what I call *portkeys to trauma* (Stolorow, 2010). In the region of trauma all duration or stretching along collapses, the traumatic past becomes present, and future loses all meaning other than endless repetition. Because trauma so profoundly modifies the universal or shared structure

of temporality, the traumatized person quite literally lives in another kind of reality, an experiential world felt to be incommensurable with those of others. This felt incommensurability, in turn, contributes to the sense of alienation and estrangement from other human beings that typically haunts the traumatized person.

The relentlesss recurrence of emotional trauma is ensured by the finitude[2] of our existence and the finitude of all those we love. Authentic temporality, insofar as it owns up to human finitude, is traumatic temporality. "Trauma recovery" is an oxymoron—human finitude with its traumatizing impact is not an illness from which one can recover. "Recovery" is a misnomer for the constitution of an expanded emotional world that coexists alongside the absence of the one that has been shattered by trauma. The expanded world and the absent shattered world may be more or less integrated or dissociated, depending on the degree to which the unbearable emotional pain evoked by the traumatic shattering has become integrated or remains dissociated *defensively*, which depends in turn on the extent to which such pain has found a relational home—a context of emotional understanding—in which it could be held. This is the essential fracturing at the heart of traumatic temporality.

When emotional trauma becomes integrated within a holding relational home, nothing disappears. Rather, such integration is felt as a relative ease of passage between the two worlds that had been kept apart by dissociation. In the therapeutic situation, such a relational home is constituted through a comportment that I call *emotional dwelling* (Stolorow, 2014). In dwelling, one does not merely seek empathically to understand the other's emotional pain from the other's perspective. One does that, but much more. In dwelling, one leans into the other's emotional pain and participates in it, perhaps with aid of one's own analogous experiences of pain. I have found that this active, engaged, participatory comportment is especially important in the therapeutic approach to emotional trauma. The language that one uses to address another's experience of emotional trauma meets the trauma head-on, articulating the unbearable and the unendurable, saying the unsayable, unmitigated by any efforts to

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[1] *Temporality* is the lived experience of time.

[2] *Finitude* is the term used by philosophers to refer to dimensions of human limitedness, especially mortality, but also powerlessness, vulnerability, and uncertainty.

soothe, comfort, encourage, or reassure—such efforts invariably being experienced by the other as a shunning or turning away from his or her traumatized state. If we are to be an understanding relational home for a traumatized person, we must tolerate, even draw upon, our own emotional vulnerabilities so that we can dwell unflinchingly with his or her unbearable and recurring emotional pain. When we dwell with others' unendurable pain, their shattered emotional worlds are enabled to shine with a kind of sacredness that calls forth an understanding and caring engagement within which traumatized states can be gradually transformed into bearable painful feelings. Emotional pain and vulnerability that find a hospitable relational home can be seamlessly and constitutively integrated into whom one experiences oneself as being.

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Embracing the Legitimacy of Dissociative Identity Disorder: An Opportunity for Trauma Psychologists to Stand United

Charles A. Benincasa, MA and Tyson D. Bailey, PsyD ABPP

Narratives emerging from the #MeToo movement have illuminated the pervasiveness of sexual assault and positioned the associated psychological impacts within a broader sociopolitical discourse. The eruption of #MeToo anecdotes has also provided a commentary on the ways that social, legal, political, and cultural systems coalesce to protect individuals in positions of power and privilege. Research exploring the reasons that sexual violence goes underreported substantiates these anecdotes (Bergman, Langhout, Palmieri, Cortina, & Fitzgerald, 2002; Kaiser & Miller, 2001). Reporters of sexual harassment, assault, and abuse are often discredited, accused of misperceiving intentions, blamed for their supposed role, and/or alleged to have made up false claims (Ahrens, 2006; Du Mont, Miller & Myhr, 2003). Some literature refers to these sociocultural biases as "rape myths" (Suarez & Gadalla, 2010). Negative encounters with social systems, including experiences of being blamed or not being believed, have been shown to be associated with significant increases in posttraumatic stress symptoms (Campbell et al., 1999).

For individuals who have experienced multiple or repeated traumas, the deleterious effects of traumatic stress compound with the re-traumatizing effects of biases and myths that still pervade legal, medical, and mental health systems. One population for whom this is particularly true includes individuals with the neurobiological organization of Dissociative Identity Disorder (DID). Providers who regularly work with individuals with DID are accustomed to hearing stories of not being believed, being accused of malingering or factitiousness, or being told that DID is not a legitimate psychiatric construct (Dalenberg et al., 2014). In addition to the myths associated with assault and abuse, individuals with DID are also subjected to unsubstantiated myths (Brand et al., 2016). The prevalence and pervasiveness of such myths results in the ascription of excessive pathology, rendering of misdiagnosis, and subjection to contraindicated treatments (Hodas, 2006).

Authors who dispute the legitimacy of DID often rely on myths, debunked literature, and personal skepticism. It is reasonable to question the degree to which this skepticism is emboldened by subtle forms of neurological privilege; i.e. the existence of autonomous identity states may seem incomprehensible for those who have not needed to rely upon dissociative survival strategies. Yet, the features of dissociated identity states, as included in scientific literature, have represented a theoretically consistent construct for over 200 years (for a thorough overview, see Dell & O'Neil, 2010).

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Dissociation, generally, is an adaptive, hardwired neurobiological survival strategy that exists in other mammals, not just humans (for a review of the neurobiology of dissociation, see Lanius, Paulsen, & Corrigan, 2014). With the contemporary advancements of neuroimaging technology, DID has been further validated as a neurobiological organization that develops when children repeatedly rely on dissociation to tolerate overwhelming life-threat states.

Of the most persistent and harmful myths about DID are that this neurobiological adaptation to extreme stress is an iatrogenic disorder and that treatment for DID is harmful (e.g., Lilienfeld, 2007). Although authors who discuss the Fantasy Model (FM) have made numerous claims that dissociative disorders (DD), particularly DID, are fabricated by individuals who are prone to engage in fantasy and susceptible to influence from powerful others—such as a therapist (Giesbrecht, Lynn, Lilienfeld, & Merckelbach, 2008; Lynn et al., 2014)—other researchers have convincingly demonstrated how individuals with authentic DID are distinguishable from simulators, including those with high fantasy-proneness, along objective personality, neurological, and physiological metrics (Brand, & Chasson, 2015; Reinders et al., 2018; Reinders, Willemsen, Vos, den Boer, & Nijenhuis, 2012). Additionally, when considering the available research evidence, antecedent trauma remains associated with the development of dissociation and various DDs as a strategy for mediating extreme, persistent stress (Dalenberg et al., 2012; Dalenberg et al., 2014; Dorahy et al., 2014).

In a study comparing responses to neutral and trauma-related stimuli among individuals with DID, high fantasy-prone non-dissociative controls, and low fantasy-prone non-dissociative controls, Reinders, Willemsen, Vos, den Boer, and Nijenhuis (2012) found that the DID group was distinguishable with statistical significance across multiple physiological and neurological metrics,

including regional cerebral blood flow in multiple brain regions, heart rate frequency, and blood pressure. Additionally, Reinders et al. (2018) established a neuroimaging classification that can identify DID using individual neuroanatomical biomarkers with 71.88% sensitivity and 73.81% specificity. As DID continues to be validated through the use of neuroimaging technology, scientific evidence suggests that DID is not a disorder of sociocultural or iatrogenic origin. Unfortunately, FM tenants are often presented in psychology textbooks as verified theories, which can perpetuate the harmful myths that further invalidate individuals living with the experience of DID (Wilgus, Packer, Lile-King, Miller-Perrin, & Brand, 2015).

As with any other clinical concern, it is important to properly assess for dissociation and rule out other potential disorders before rendering a diagnosis of DID. Methods for trauma-informed psychological assessment have expanded significantly over the past two decades with notable advancements in the comprehensive understanding of dissociative experiences (for a review, see Brand, Webermann, & Frankel, 2016). Consequently, there are well-validated methods for accurately assessing and diagnosing DID (as well as ruling out DID) that are, unfortunately, not common in mainstream clinical and forensic assessment. Structured interviews, such as the Structured Clinical Interview of Dissociative Disorders-Revised (Steinberg, 1994) provide a guided format for gathering information about symptoms in a standardized manner. Further, objective measures including the Multiscale Dissociation Inventory (MDI; Briere, Weathers, & Runtz, 2005) and the Multidimensional Inventory of Dissociation (MID; Dell, 2006) provide comprehensive information about the presence of multiple forms of dissociative sequalae. Validity indicators on the MID also assess for conditions such as psychosis, rare symptoms, and borderline personality features to aid in diagnostic accuracy.

Objective personality measures have also been shown to adequately distinguish individuals with DID from simulating controls; however, it is critical to understand how the presence of dissociative symptoms may impact validity scales of commonly used measures. For instance, Brand and colleagues found particular profiles associated with individuals diagnosed with DID, including elevated validity scales on the Minnesota Multiphasic Personality Inventory-2 and Personality Assessment Inventory (Brand & Chasson, 2015; Stadnik, Brand, & Savoca, 2013). Further, the Structured Interview of Reported Symptoms-2 has been shown to potentially misclassify DDs as feigning if the

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Trauma Index is not utilized in conjunction with the overall scores (Brand, Tursich, Tzall, & Loewenstein, 2014). When considering this body of work, it is critical to note how these measures have been found to clearly differentiate simulated from genuine DID utilizing well-validated assessment measures. The comprehensive nature of these scales provides an important comparison to screening measures, such as the Structured Inventory of Malingered Symptomatology (Widows & Smith, 2005), which are supposed to be utilized as a precursor to more comprehensive analysis of symptom feigning when elevated.

All healthcare providers are tasked with the ethical imperative to avoid inflicting harm. Yet, unsubstantiated bias and myth often define the perspectives of providers who would deny the existence of DID in opposition to rigorously developed scientific evidence. Dissociative Identity Disorder continues to be an internationally accepted medical diagnosis within both the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM) classification systems. Yet, some providers discourage assessing dissociation because of personal beliefs that DID does not exist. When health care providers allow myths to permeate the ways in which social systems interface with individuals who have experienced various forms of psychological trauma, they allow for the perpetuation of re-traumatization and replication of damaging dynamics of abuse (Burke, 2019). Trauma Psychologists have a unique opportunity to take a definitive stance that dispels harmful myths, repudiates debunked literature, affirms DID as a well-validated construct, acknowledges the influence of privilege on skepticism, and advocates for the ethical assessment, diagnosis, and treatment of individuals with DID.

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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.

The Role of Trauma Core Competencies in Shaping Clinical Psychology Graduate School Education and Training

Amanda Wallick, Abbie J. Brady & Lisa M. Brown

Why are the New Haven Trauma Core Competencies important for graduate students, trainees, and psychologists? Applying a standardized set of knowledge, skills, and attitudes at all stages of professional development has the potential to improve education and training, advance standards of care, support use of evidence-based or informed practices in clinical settings, enhance delivery of care, and improve patient outcomes. Consistency in the content and quality of teaching and training programs contributes to a common shared language, defines expectations for optimal work performance, and ensures uniform quality of patient care across clinical settings. As the field of trauma psychology continues to advance, developing adequately prepared graduate students for internship training is a concern for students, faculty, universities, clinical supervisors, internship sites, and accrediting organizations.

This article describes how the New Haven Core Competencies were used to develop the Ph.D. Clinical Psychology Trauma Area of Emphasis program at Palo Alto University (PAU). It provides an overview of how the five areas of focus: 1) scientific knowledge about trauma, 2) psychosocial trauma-related assessment, 3) trauma-focused psychosocial intervention, 4) trauma-informed professionalism, and 5) trauma-informed relational and systems (Cook & Newman, 2014) were used to guide program development.

Justification for developing a Trauma Area of Emphasis was driven by student demand for advanced studies and training in this area along the growing number of internship programs offering rotations in trauma psychology. A recent search of the Association of Psychology Postdoctoral and Internship Centers (APPIC) directory using key terms to identify programs that had posted descriptions that included the word "trauma" produced 161 matches (16%) of the 1005 available internship sites. It is reasonable to anticipate that the number of trauma focused internship training opportunities will continue to grow in the years to come. To ensure that PAU clinical psychology students were well prepared for internship and possessed a solid foundation of knowledge, skills, and attitudes,

administration supported the implementation of competency-based educational programming. A faculty member with research, clinical, and program development experience was hired to serve as the Director of the Trauma Area of Emphasis. The director was tasked with developing curricula and identifying training opportunities that underpin each core competency, selecting assessments to obtain a valid and reliable evaluation for measuring learning outcomes, mentoring students, guiding dissertation research, and serving as the faculty advisor for the campus trauma club. Below is a description of various activities and endeavors at PAU that are aligned with each of the New Haven Trauma Core Competencies.

Amanda Wallick

Scientific Knowledge about Trauma

Scientific knowledge of trauma is obtained from coursework and from participating as a member of one of the seven trauma-focused research labs at PAU. Trauma-focused research labs allow students to work closely with faculty in designing projects that demonstrate their ability to critically review, analyze, and expand the existing scientific literature on trauma and resilience. Lab participation supports the development of student dissertation research through collaborative and independent research endeavors that include becoming knowledgeable about human subjects protection and IRB procedures, data collection methods, data management and analysis, and publication of manuscripts in peer-reviewed journals. Examples of topics recently addressed by several of the trauma-focused research labs at PAU include fostering resilience after traumatic events, use of trauma interventions and treatments, the intersection of trauma and personality, the effects of interpersonal trauma, mindfulness and disasters, and the use of substances after traumatic events. Lab research projects are conducted locally and globally. A specific example of a local lab activity is the *Early Intervention Clinic* (EIC) at PAU. In this lab, students are trained and then supervised using an evidenced-based treatment with people who have experienced a trauma within the past two years. Anonymized, aggregate clinical data is available for use by the *EIC* lab students for scientific presentations, manuscripts, and dissertations. Lab students are able to apply their knowledge in a real world setting, receive feedback on refining their clinical

skills, gain experience in running a clinical trial, work with an institutional review board, and contribute to a program of research. Participation in a research lab help students nurture their scientific-mindedness and establish a foundation for their professional identity. An example of a recent collaborative international project completed by students and faculty representing two labs, *Risk and Resilience Research Lab* and the *Culture, Community, and Global Mental Health Lab*, examined the effectiveness of post-trauma interventions in Central African Republic. With funding from USAID, through a grant to Catholic Relief Services, the study was designed to provide data on the psychological impact of trauma healing and peace education programs. Collaboration between labs offers PAU students extensive opportunities for professional growth by offering training and mentorship from more than one research mentor.

Comprehensive Assessment of Trauma

The second core competency, psychosocial trauma-focused assessment, addresses the importance of being able to appropriately assess and diagnose trauma-related mental health issues, note the impact that the trauma has had on the individual's capabilities, and specify the person's unique contextual factors (Cook & Newman, 2014). In part, PAU graduate students strive to meet this competency through specialized trauma-focused assessment courses. The *Assessment of Trauma* course at PAU highlights the many ways trauma can affect functioning and provides a comprehensive overview of the screeners, assessments, and batteries that can be used for detection, evaluation, diagnosis, and for guiding treatment. PAU offers adult, child, adolescent, and family assessment courses.

Graduate students who take these courses are taught how to administer trauma-specific assessments and to demonstrate their ability to administer these assessments through experiential assignments. In addition, the trauma-focused assessment course at PAU is also designed to acquaint students with ethical issues and cultural considerations that should influence selection and administration of assessment measures by clinical interview, self-report, and informant report. In a clinical training setting, graduate students learn how to assess their clients for trauma exposure and apply their knowledge of trauma to their client's case conceptualization and treatment plan. Specific training in this area provides graduate students with an understanding of and familiarity with trauma-specific assessment protocols in preparation for internship.

Abbie J. Brady

Providing Trauma-Focused Intervention

The third core competency, trauma-focused psychosocial intervention, highlights the need to address trauma-exposed individuals' global well-being through evidence-based psychosocial interventions (Cook & Newman, 2014). For PAU graduate students, working towards this competency includes completing coursework that is required for the Trauma Area of Emphasis. The courses are sequential and begin with Foundations of Trauma, followed by Assessment of Trauma and Treatment of Trauma. Topics covered within these courses include the multifaceted presentations of trauma, considerations when assessing and treating trauma, and use of validated assessments and evidence-based treatments. These courses encourage class discussions as a way to foster consideration of client characteristics, comorbidities, culture, level of resiliency, available resources, and recovery environment. This approach allows for students to generate appropriate case conceptualizations and identify appropriate treatments for use with clients from diverse cultural backgrounds. To ensure that PAU graduate students are meeting optimal standards of quality and performance, the Trauma Area of Emphasis uses a structured approach that begins with attainment of knowledge from foundational coursework that is later applied in supervised clinical settings.

Coursework and clinical training is augmented by Trauma Grand Round lectures that are organized by a student-run organization, the Association of Traumatic Stress Studies. Trauma Grand Rounds are offered quarterly and focus on trauma-specific assessment, intervention, cutting-edge research, and professional development. Recent speakers include the deputy director for dissemination and training at the National Center for PTSD and Stanford faculty who are national experts in telemental health. Examples of topics addressed include using technology to augment existing trauma-specific treatments, identifying risk factors for childbirth-related trauma, and evidence-based care for veterans with PTSD. In addition to learning from leading experts in trauma, students have an opportunity to make professional connections, familiarize themselves with the process of earning CEUs, and become appreciative of the importance of staying up-to-date with the scientific literature at all stages in their respective careers. PAU incorporates the New Haven Core Competency of trauma-focused psychosocial intervention by creating tailored course work experiences and allowing for unique opportunities to interact with professionals with expertise in some facet of trauma research, clinical care, or program development. This

individualized training curriculum allows PAU graduate students to acquire the knowledge, skills, and attitudes necessary to appropriately implement psychosocial interventions for trauma-related disorders.

Trauma-Informed Professionalism

The fourth core competency, trauma-informed professionalism, encompasses professional values and ethics, integrity, cultural humility, and ability to work effectively with traumatized populations, other professionals, and staff members (Cook & Newman, 2014). In this area graduate students work towards achieving competency by learning the APA code of ethics and then demonstrating their understanding of the ethical codes when conducting research, engaging with clients, interacting with other students and faculty, and when receiving feedback during supervision. PAU graduate students have opportunities to engage professionally through their research labs, leadership roles in student and professional organizations, and during their supervised clinical experiences. The Gronowski Center is a PAU outpatient psychology training clinic where graduate students are audio and video recorded providing therapy to their clients. Clinical supervisors review recordings and provide individual and group feedback that focuses on the development of the students' skills and professional clinical identity. Quarterly reviews document the progress of each student's ethical decision-making skills, ability to receive and incorporate feedback into the sessions, and skills in treating clients, including those who have experienced trauma. This competency also addresses the extent to which graduate students are able to identify ways that their client's cultural beliefs and practices shape the expression of their trauma symptoms and influences their engagement in treatment. Students also have the option to consult with other supervisors to enhance their cultural competence. As graduate students progress through their doctoral training this competency evolves from meeting required benchmarks that indicate acquisition of knowledge and fundamental skills to the integration of ethics and cultural competence. This integration comprises a foundation component of their professional and ethical identities as early career psychologists.

Engaging With Trauma-Informed Systems

The final core competency, trauma-informed relational and systems, addresses an ability to effectively and conscientiously engage with traumatized individuals, groups, and/or communities (Cook & Newman, 2014).

Lisa M. Brown

Evidence of making progress towards this competency is demonstrated when graduate students are able to articulate their knowledge of the debilitating effects of trauma and demonstrate their ability to respond appropriately to their clients' experiences. Graduate students also incorporate this competency into all facets of their clinical work. One example is consulting with other professionals regarding trauma-informed treatment modalities that promote resilience, recovery, and healing. Understanding this competency also means that graduate students are able to acknowledge and demonstrate an awareness of intergenerational and cultural factors that may contribute to a trauma's impact and address the ways that these factors could be treated. As a growing body of research continues to reveal trauma's wide-reaching and enduring effects, the need for specialized training becomes increasingly important. PAU's *Foundations of Trauma Psychology* course was so popular this year that an additional section needed to be added to the schedule. Graduate students from other areas of emphasis including forensics, mindfulness and meditation, and neuropsychology enrolled in the *Foundations of Trauma* course as a step towards applying trauma-informed care approaches into their respective areas of specialization.

By using the New Haven Core Competencies to develop PAU's doctoral program trauma courses, graduate students are well prepared for internship. Specifically, graduate students are able to demonstrate specific abilities and meet minimal quality and performance standards, rather than relying solely on the accrual of hours and completion of coursework as a representation of readiness for the next stage in their training. The New Haven Core Competencies help supervisors and academic mentors identify the educational and experiential standards doctoral level students studying trauma should aim for as they become increasingly more independent. While successful completion of doctoral courses that are aligned with the New Haven Core Competencies is only one component of the educational and clinical training necessary to become a competent psychologist, these important competencies provide a template for lifelong learning and training.

Amanda Wallick *graduated in 2016 from the University of Nevada, Las Vegas with a B.A. in Psychology and a minor in Marriage and Family Therapy. Currently, Amanda is a 2nd year clinical psychology PhD student pursuing the trauma area of emphasis at Palo Alto University. She recently first-authored a book chapter on resiliency and mental health and is currently serving as secretary for the Association*

of Traumatic Stress Studies for the 2018-2019 academic year. Additionally, Amanda was recently elected as APA Campus Ambassador for Palo Alto University. Amanda is a research assistant in the Risk and Resilience Research Lab and the Army Study to Assess Risk and Resilience in Service members (Army STARRS) Research Lab. Her research interests include trauma/PTSD, severe mental illness, and personality. She is a student affiliate of APA Division 56 (Trauma Psychology), the Association for Psychological Science (APS), as well as the International Society for Traumatic Stress Studies (ISTSS).

Abbie is a 2nd year PhD student in the Trauma emphasis of the Clinical Psychology program at Palo Alto University. She received her BA from Ashland University in Ashland, OH. Abbie's clinical interests include working with veterans and active duty military members, and recovery-based models of treatment. Her research interests revolve around the same populations and specifically involve military culture, social support, and unit cohesion. Abbie is currently completing her internal practicum at the Gronowski Center and is a research extern at the National Center for PTSD at PAVA: Menlo Park Division.

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).

Intern Call: 2019-2020
Association for Trauma Outreach and Prevention (ATOP)

Mission: *At **Meaningfulworld**, the ultimate goal is to prepare a generation of conscientious individuals who are guided by love, peace, passion, and meaning. **Meaningfulworld** is dedicated to fostering a meaningful, peaceful, and just world in which every individual enjoys physical, mental, social, economic, and spiritual health. A sense of meaning, peace, and justice, although unique to everyone, is achieved through a transformative journey that integrates knowledge and experience with a sense of responsibility and reflection. We have monthly clinical workshops, annual humanitarian missions, and accredited at the United Nations.*

Available Positions: All internships are conducted under the supervision of both Dr. Ani Kalayjian-Founder and CEO, Board of Directors of ATOP, and the Intern Coordinator Meredith Carbonell.

1. **Grant Writer/Researcher:** Assisting the Grant Committee to research & write grants, apply for awards, disseminate the work through printed materials

2. **United Nations Intern:** Presence is essential on Thursdays to attend international meetings & join DPI and CoNGO Committees. One year minimum.

3. **Webmaster:** Upload photos, press release, and reports on our website.

4. **Research Intern:** Taking part in our active research team with local and international research from around the world.

5. **Fundraising Intern:** To maintain sustainability of our organization, organizing fundraising events for social gatherings to raise funds.

6. **Clinical Coordinator and Assistant Coordinator:** Managing monthly educational workshops.

Location: Although based in the New York Metropolitan Tri-State area, USA, international internships are also welcomed. Internship requirements can be fulfilled from home (own state or country) and may lead to travel opportunities. Monthly tele-conferences are mandatory, first Monday eve. Monthly workshops on the last Saturday of each month (Sept-May) are mandatory in NYC.

Time Commitment: 12 months–2 years, 5-7 hours a week (some internship less hours)

Kindly send your resume, statement of purpose, internship position of interest, 3 goals consistent with our mission, and names & contacts of 2 references to Dr. Kalayjian DrKalayjian@meaningfulworld.com, kindly visit: www.meaningfulworld.com

International Committee Report

Elizabeth Carll, PhD

As part of the series of interviews conducted by student members with trauma psychologists from various parts of the world, **Laura Captari,** a student member of the International Committee, interviewed **Dr**. **Brian J. Hall,** an Associate Professor of Psychology and Director of the Global and Community Mental Health Research Group, Department of Psychology at the University of Macau in China.

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

To encourage participation of international students at the APA convention, the Division approved an annual **$1000 Student Travel Stipend** including convention registration to support travel of a student from a developing country, who has a trauma related poster or paper accepted for the presentation at the convention. The 2019 APA Convention will take place in Chicago, Illinois. A free one-year membership in Division 56 is also included. Interested candidates for the travel stipend should contact: Dr. Elizabeth Carll, at ecarll@optonline.net.

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

An International Committee Interview with Brian J. Hall, Ph.D.

By Laura Captari, M.A., M.S.

Dr. Brian Hall is Associate Professor of Psychology and Director of the Global and Community Mental Health Research Group, Department of Psychology at the University of Macau, and Visiting Associate Professor at Johns Hopkins Bloomberg School of Public Health. He was recently appointed as a Fellow of the Chinese Academy of Sciences and has consulted with the World Health Organization, UNAIDS, and UNICEF.

At the intersection of trauma and public health, Dr.

Elizabeth Carll

Hall's work addresses health disparities in order to create policy and systemic changes, particularly among migrant populations. How did this all get started? As an undergraduate student interning at The Free Clinic of Greater Cleveland, in Cleveland, Ohio, Hall noticed that although most clients sought treatment due to physical ailments or substance use, "trauma was a major—but often unspoken—critical part of their life stories."

Dr. Hall views research as a powerful means of advocacy for social justice and equity among oppressed and marginalized groups. He is particularly interested in the larger ecological systems and sociocultural influences that shape mental and physical health. "Trauma is just one piece of a larger puzzle," he reflects. "It's vital to develop a holistic understanding of population health and consider not just individual stressors and behavior, but also what is happening *outside* of the person—within the larger community and culture—that shapes their health."

Over the last 15 years, Dr. Hall has been involved in intervention and population-level research among vulnerable and at-risk communities globally. Throughout graduate school and as a NIMH T32 pre- and postdoctoral fellow, he documented the impacts of natural disasters, terrorism, forced migration, and sexual violence in multiple contexts. While teaching a university course in Macao (SAR) China, as a postdoc, Dr. Hall became curious about the many Filipino and Indonesian migrant workers in the region.

What unique challenges are these migrants facing? What contextual factors might be influencing their physical and mental health?

Questions such as these led Dr. Hall to pursue the Fogarty Global Health Fellowship in order to develop a program of research around migrant health, working with African migrants in Guangzhou, China, before transitioning to a position in Macao. He is also the inaugural APA-IUPsyS Global Mental Health Fellow, which allowed him to work on a team to develop the cultural guidelines for mental, behavioral, and neurodevelopmental disorders in the ICD-11. Reflecting on what he's learned through cross-cultural research, Dr. Hall notes, "It's vital to make communities active participants in the research process." This included joining migrant workers in community activities, sharing meals together, building relationships, dialoguing, and just listening. In addition, collaborations with government consulates and non-profit organizations set the stage for policy impacts.

"My team's desire is to join with marginalized communities to document the social determinants of health to better understand how to address health disparities." One important discovery for Hall has been the multi-faceted nature of trauma exposure among migrant workers. Over half of Filipino and Indonesian migrants reported some form of natural disaster as their key index trauma. Compromised economic conditions and lack of resources frequently necessitate employment abroad to support their family members back home. Despite deleterious work conditions, long hours, and at times labor abuses, migrants in south China are fueled by commitment to their families and make tremendous sacrifices to create a better life.

Dr. Hall emphasized the importance of attending to cultural nuances rather than imposing a Western diagnostic perspective in trauma research. This has included validating common trauma instruments within migrant communities as well as utilizing qualitative and ethnographic approaches to capture cultural understandings of health and illness. When working with trauma cross-culturally, Dr. Hall pointed out the vital importance of recognizing the historical backdrop of colonialism, exposing oppressive hierarchies that exist both between and within communities, and always maintaining empirical skepticism.

For example, while research has documented the buffering effects of social support, a different narrative emerged among Filipino migrants. "We found that those with greater social support reported more psychological distress. In a highly collectivistic culture, social interactions frequently become contexts for venting about family stress, employment challenges, and lack of control. Group rumination and emotional contagion seem to pose greater risks due to a high demand for reciprocity, such that social contexts may increase the burden of stress." Dr. Hall's ongoing research seeks to document different types of support within migrant workers' networks, including relationships that might be more helpful versus emotionally taxing.

Among migrants, there are numerous structural barriers to intervention, including lack of autonomy in the workplace and biases surrounding mental illness.

"In many people's mind, if you have a mental health problem, you're crazy, and no one wants to be seen that way." In Macao there are very few mental health providers. Dr. Hall is currently one of four doctoral-level psychologists, with the burden of care being addressed primarily by social workers, master-level clinical psychologists, and a few psychiatrists. "Cultures without psychotherapy frequently have other healing mechanisms built into the community," Dr. Hall notes. Two potential intervention points under investigation are peer-based/community support and digitally supported mental health treatments.


Brian J. Hall

Hearing about the complexity and challenges inherent to this work, I was curious about what motivates and energizes him. Dr. Hall spoke about creating long-term systemic change. "There's nothing in global health that happens overnight. I try to pay attention to communities that are invisible—and develop a body of empirical evidence so the world knows about the disparities these populations face." Currently, migrant organizations are using findings to advocate for policy changes that address less than optimal labor practices, policy enforcement, and lack of access to health care.

In speaking to others engaged with international development and trauma work, Dr. Hall reflects, "It's natural to be discouraged. Living cross-culturally brings with it unique stressors. I don't always see the impact that I hope our work will have, and I've had to adjust a lot of expectations. But, I go to work every day focusing on the mission and the endgame."

What is that endgame? To create sustainable, health promoting programs among marginalized groups. For Hall, a major means to that end is mentoring emerging leaders in the field of psychology and public health in China and the region, beginning with his own students and trainees.
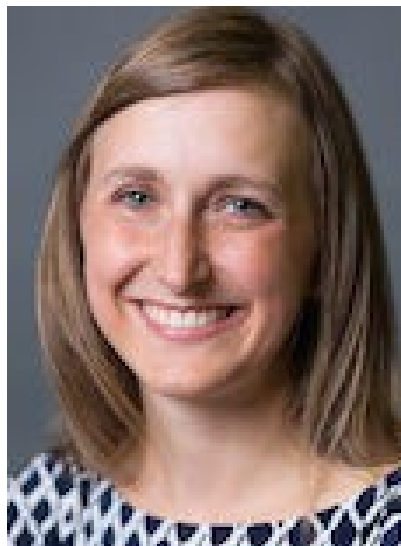
Laura Captari

Laura Captari is a doctoral candidate at the University of North Texas and incoming pre-doctoral intern at Beth Israel Medical Center in New York. Her research investigates the developmental impacts of trauma, disaster, and loss, including the roles of attachment, spirituality, and cultural factors in facilitating resilience and post-traumatic growth. She is a member of the International Committee of Division 56.

Transforming the Epidemic of Gender-Based Violence: The Case of Caribbean Immigrant Communities
The 7-Step Integrative Healing Model

Patricia Mura Desert and Dr. Ani Kalayjian

Introduction

Gender-Based Violence (GBV) is defined as abuse that is directed toward women and girls because of their gender (International Organization for Migration [IOM], 2018). GBV includes "gendercide, sexual assault, intimate partner violence, emotional abuse, economic abuse, denial of resources and forced sex" (IOM, 2018). GBV is considered one of the "most rampant human rights violations against women and girls in the world" (United Nations Population Fund [UNPF], 2018). According to the World Health Organization (WHO) global report (2014) conducted in 133 countries, "1 in 5 women was sexually abused as a child." GBV, when used as a weapon in war through mass rapes and killings of women, is referred to as gendercide. GBV also occurred in 1895-1918, by the Ottoman Turks during the genocide towards Armenians and Greeks, as well as during the genocide in Rwanda (Kalayjian & Eugene, 2010, p. 309). According to WHO (2015), over 30 percent of the world's women have suffered physical or sexual abuse by a partner. Between 100 and 140 million girls and women have undergone female genital mutilation. More than 60 million women were married before their 18th birthday, many of them by force. GBV is a global pandemic and a public health crisis. GBV can take different forms in different parts of the world based on cultural perspectives on gender equality and patriarchal traditions.

Despite increased consciousness of violence worldwide and widespread human rights education, levels of violence against women remain unacceptably high.

Discriminatory policies and practices affect, not just women, but entire communities and nations. These discriminations are often done in the name of culture, honor, or tradition. Research shows that countries where women lack ownership rights to land or access to credit have significantly more malnourished children (2012, United Nations, Secretary-General message). Therefore, investing in women is investing in humanity and international sustainable development. Even countries such as the United States of America with its diverse resources still maintain disparity in what women and

Patricia Mura Desert

men are paid for the same work, as well as continuing under-representation of women in political and business decision-making. **Background**

GBV is a challenge especially affecting immigrant women from Caribbean countries, where sexual violence against women is predominant. A recent report by the United Nation International Children Emergency Fund (UNICEF) stated that "42.7% of girls in the Caribbean are forced into their first sexual experience by the age of 12, and the rate of sexual violence in Caribbean countries is "higher than the global average" (UNICEF, 2013). Studies suggest that Caribbean women suffer greatly from the psychological impact of family violence even after immigrating to the United States (U.S.), and they continue to face cultural barriers preventing connection to mental health services (Balboolal, 2016; Edge & Rodgers, 2005; Greenidge, 2016; Greenidge & Daire, 2010). Researchers found that there is a culture of silence in Caribbean communities that prevents female victims of intimate partner violence, rape, incest, and other forms of domestic violence from reporting these incidents or seeking help (Jeremiah, Quinn & Alexis, 2018; Reid, Reddock & Nikenig, 2014).

Although there is a scarcity of organizations targeting specifically Caribbean survivors of domestic violence living in the U.S., there has been development addressing GBV internationally through non-profit organizations. This paper is a review of the work that the IOM, the UN, and the Association for Trauma Prevention and Outreach Meaningfulworld are doing to address GBV and find ways to intervene, heal, and transform.

What is International Organization for Migration doing about GBV?

The IOM's operational model outlines important steps that should be considered when addressing GBV in the community. These three important steps are to "1) mitigate risks, 2) support survivors and 3) address the root causes" (IOM, 2018). In the first step of the operational model, "mitigating the risk," IOM recommends for service providers to take a "do no harm"

approach when setting up programs to assist women and girl victims of violence in order to preserve the dignity and safety of each individual (IOM, 2018). The second step is to train staff on how to best address these challenges, improve community access to preventive services, and educate survivors about these services (IOM, 2018). The third step is to design services that address the root causes of violence in the community such as inequality, low access to services, or patriarchal cultures (IOM, 2018). This operational model is not only effective for international outreach but can also be applied locally to serve immigrant survivors in the U.S. who continue to face family violence geared towards women.

What is the United Nations doing about GBV?

In 2015, the United Nations Population Fund (UNPF) invested $93 million dollars to improve access to social services for survivors, and the funds were used to reform national policies, develop local programs, and initiate partnerships with communities toward ending GBV (UNFP, 2017). The development of local social service programs has proven to be effective in addressing GBV on individual and community levels (IOM, 2018). The UN has also developed a mobile outreach program equipped with mental health professionals to assist local domestic violence survivors (UNFP, 2018). Through the Partnership for Peace (PfP) program, the UN has developed a diversion program aiming to educate perpetrators and evaluate the impact of such intervention in the lives of women (Jeremiah et al., 2014). In the past five years, the UNPF and the IOM encouraged organizations to "think global and act local" to move toward accomplishing goals such as ending violence against women. UN Sustainable Development Goals (SDGs) provide guides to help women. For example, SDG 3 addresses working toward health and well-being, SDG 5 addresses working toward equality, SDG 10 addresses reducing inequalities, and SDG 16 addresses working toward peace and justice.

What is ATOP Meaningfulworld doing about GBV Internationally?

The Association for Outreach and Prevention (ATOP) Meaningfulworld, as a humanitarian organization, has embraced the slogan, "Think global, act local." In the past 30 years, ATOP Meaningfulworld has traveled to 46 countries and 25 U.S. states to educate communities affected by natural and human-made disasters. Researchers have found that GBV increases after natural disasters (Elisabeth et al., 2016; Kalayjian

Ani Kalayjian

& Eugene 2010; Khan, 2016). ATOP Meaningfulworld humanitarian service is three pronged: first, it provides healing and education; second, it conducts research; and third, it informs policy revision. Team members share knowledge on emotional intelligence, resilience, mind-body-eco-spirit practices, and integrative healing methods in order to prevent GBV and promote peaceful healing. ATOP Meaningfulworld has been successful with its outreach in many regions of the world, including Africa (Kenya, Sierra Leone, Rwanda, DR Congo, and Burundi), Asia (China, Korea, Pakistan, and Sri Lanka), the Caribbean (Haiti and Dominican Republic), the Middle East (Palestine, Israel, Lebanon, Syria, Jordan, Egypt, and Saudi Arabia), previously Soviet countries (Armenia, Romania, and Russia), North America (25 U.S. states), and South America (Mexico and Argentina).

Since 2010, immediately after the devastating earthquake in Haiti, and continuing until today, our teams provide workshops, healing groups, and educational programs on mindful education, emotional intelligence, human rights, and gender sensitivity. We work with men and women, young and old. We work in children's centers (orphanages), women's centers, men's centers, universities, seminaries, prisons, bars, military, Ministries of Health, Education, and Social Welfare, police, and coast guard to ensure that our workshops have been inclusive and our outreach has been as wide as possible.

Although initially the Haitian community shared extremely discriminatory views about women and girls, after our workshops almost 60% of the attendees showed reduction of violence against women in their expressions, thoughts, and views. Ultimately, what is clear is that interventions comprised of mindful education, knowledge building, skill building, assertiveness training, head-heart-hand alignment, and emotional intelligence show the most promise and investing in these educational programs is a necessary investment in humanity.

The Seven-Step Integrative Healing Model

ATOP Meaningfulworld utilizes the Seven-Step Integrative Healing Model (Kalayjian, 2010) to achieve its goal of reducing GBV. The Seven-Step Integrative Healing Model is an integrative tool that can be taught to psychotherapists and non-mental health providers. The model promotes the assessment and expression of feelings, empathy and validation, discovery of positive meaning, sharing resources, connecting with Mother Earth, and "Soul-Surfing" (Kalayjian, 2017). Soul-Surfing is an exercise that integrates deep breathing
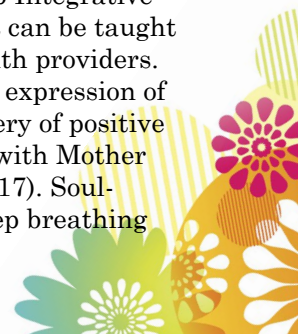
with movement, positive affirmations, color and organ consciousness, and essential oils (Kalayjian, 2017). This healing model embodies the core concepts of IOM of mitigating risks, supporting survivors, and addressing the root causes. By educating locals on how to balance their emotions and care for their mental health, ATOP Meaningfulworld empowers communities in distress, contributes toward sustainable positive change, and reduces the cycle of violence.

The Seven-Step Integrative Healing Model has been demonstrated to be effective in both international and national Caribbean communities because of its culturally sensitive and integrative nature. The model combines spiritual, ecological, and psychological practice into one model in order to facilitate the healing process for survivors. The model places the survivor at the center not only to receive resources, but to seek and restore emotional health. During several Humanitarian Missions to Haiti, ATOP Meaningfulworld ambassadors have engaged local survivors and perpetrators alike in the healthy expression of emotions, sharing empathy, understanding each other's experiences, and, most of all, connecting to ecological resources as a source of healing power. During the process, participants reported feeling safe to share their personal trauma surrounding family violence and beginning to develop healthy coping habits to expedite their healing.

The following statements exemplify the negative thoughts they initially possessed: "Girls can't play basketball," "women can't own a farm," "women are weak and can't lead the home," and "women can't be leaders, because they menstruate."

Fortunately, after our workshops, these negative statements transformed into: "Girls could play any sport they wish," "Women and men have different physical strengths, we could help one another," "women can lead well, as they are very compassionate, forgiving, and give unconditional love."

Discussion

The Seven-Step Integrative Healing Model can be used for outreach to domestic violence survivors residing in the U.S. Many GBV survivors who have since immigrated to the U.S. continue the cycle of violence and silence because they now face additional barriers to services such as documentation, language, and foreign culture. The interpersonal nature of the model has also been shown to be a fit for Caribbean survivors, who tend to utilize informal resources such as their family and friends, when seeking help. This framework encourages sharing of information and resources from their own traditional practices and eliminates the fear of going directly to a formal source as a first step to getting help. Just as the UN created the mobile team for assisting survivors who would not otherwise seek services, ATOP Meaningfulworld provides local monthly workshops

for small groups of individuals. Instead of simply giving a prescription, ATOP Meaningfulworld initiates a community healing and dialogue. This community dialogue can be a powerful tool in creating sustainable outcome where survivors can contribute toward ending the generational cycle of GBV.

Recommendations for Further Research

GBV in the Caribbean community is highly underreported and the literature around Caribbean women's experience of GBV is scarce. Researchers can explore the effectiveness of existing social services in serving Caribbean immigrant survivors. Further research is recommended to corroborate the effectiveness of the Seven-Step Integrative Healing Model in Caribbean communities. Additionally, research could focus on ending the perpetual silence in Caribbean communities regarding GBV.

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Teachers College's Distinguished Alumni of the Year; the citation stated: "You have devoted your life to studying the impact of trauma and to helping others to heal. That calling grows out of your family's history and your own: As an Armenian child in Syria, where your family had sought refuge from the Ottoman Turkish Genocide of Armenians, you lived with the constant sadness & fear. In a sense, your life since then has been- to borrow a phrase from your own writings- about channeling the sense of helplessness that one feels in such moments into the work of helping others. You have treated, studied, and helped transform survivors of both natural and human-made disasters from around the world. As your protégé wrote 'What is extraordinary about my teacher and mentor is her unrelenting commitment to bettering society by unifying minds, hearts and spirits; emphasizing likeness in human beings and celebration of differences. She is steadfast in her optimism that prevention of human-made trauma and resilience post natural disasters can be realized and nurtured through forgiveness, tolerance, ancestral healing and respect for all humanity and mother earth." She has over 100 published articles in international journals, is an author of Disaster & Mass Trauma, as well as Chief Editor of Forgiveness & Reconciliation: Psychological Pathways to Conflict Transformation and Peace Building (Springer, 2010), Chief Editor of II Volumes on Mass Trauma & Emotional Healing around the World: Rituals and Practices for Resilience and Meaning-Making (Praeger, ABC-CLIO 2010), author of Amazon bestseller Forget Me Not: 7 steps for Healing our Body, Mind, Spirit, and Mother Earth (2018), author of a meditation CD called "From War To Peace" transforming generational trauma into healing and meaning-making, Soul-Surfing, and has created 10 films on Meaningfulworld Humanitarian Outreach Programs around the world.

Book Review—*Baffled by Love: Stories of the Lasting Impact of Childhood Trauma Inflicted by Loved Ones*

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Kahn, L. (2017). *Baffled by love: Stories of the lasting impact of childhood trauma inflicted by loved ones.* Berkeley, CA: She Writes Press.

Working with individuals who have experienced child maltreatment at the hands of loved ones requires clinical expertise grounded in trauma research as well as the ability to bear witness to devastating emotional pain while managing one's thoughts, feelings, and behaviors. In *Baffled by Love*, Kahn beautifully demonstrates this skillset. Kahn's ability to understand and connect with her clients while consistently self reflecting on the therapeutic dance that she is engaged in highlights a learned art that trauma clinicians aspire to possess.

Kahn transparently and courageously intertwines her professional and personal experiences which provides invaluable insight into the multifaceted and complex relational issues that are at the core of trauma work. Kahn deeply explores the early relational injuries that significantly impact the psychosocial trajectory of trauma survivors. The systemic implications of relational trauma are clearly addressed in Kahn's reflections which reinforce the need for trauma clinicians to understand the context of clients' lives and how unprocessed trauma influences one's self concept, spilling over into various roles including how one functions as a partner, parent, friend, colleague, employee, etc. This close examination of the lived experiences of childhood trauma survivors and the many ways they endure ongoing developmental struggles across domains of functioning, assists trauma clinicians in better understanding the nuanced strengths and

BAFFLED BY LOVE

Stories of the Lasting Impact of Childhood Trauma Inflicted by Loved Ones

LAURIE KAHN
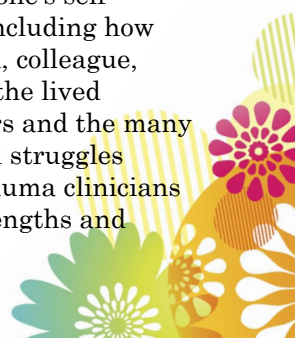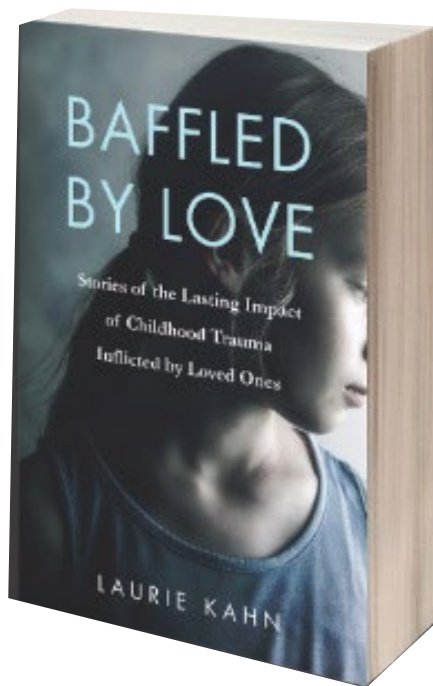
challenges of trauma survivors which in turn allows trauma clinicians to be better equipped to support trauma survivors on their path of healing.

Among many important therapeutic issues raised, Kahn explains the delicate balance of developing a trusting relationship with clients while being mindful of known and unknown trauma triggers. She provides specific examples of how she navigates relationship building and ways that she has attempted to repair ruptures in the therapeutic relationship. Additionally, Kahn shares her own moments of vulnerability in therapeutic encounters that have ultimately led to personal and professional growth.

This emphasis on creating opportunities for a corrective relational experience is supported by the seminal work of childhood trauma experts. Caffaro (2017) describes the necessity to utilize a relational, strength based approach when working with childhood trauma survivors, specifically child sexual abuse survivors. He explains the critical need to recognize and examine the relational dynamics between client and clinician and how they connect to the client's trauma history. Courtois (2010) explains that clinicians need to create a therapeutic environment that is supportive of the client while also challenging the client to develop the capacity to self soothe with the goal of enhancing their affect regulation skills. These perspectives, rooted in attachment, align with Kahn's efforts to share the intricacy of the trauma work that she and her clients engage in while reinforcing that the quality of the therapeutic relationship is key to relational healing.

A core concept, shared by Kahn, is that love is central to the therapeutic relationship. She pushes clinicians to consider how the therapeutic relationship can

provide a reparative relational experience that allows clients to restore the capacity to love and be loved. Her explanation of how love informs her work and ultimately impacts client outcomes, provides guidance for clinicians navigating these murky waters.

In the field of trauma, it is well known that working with childhood trauma survivors requires careful and intentional efforts to create safe spaces and develop trust. While this is well known, it is easier said than done. As Kahn eloquently explains, the therapeutic relationship is fragile and ebbs and flows between moments of connection and disconnection and the moments of disconnection are often rooted in interpersonal trauma histories. Kahn's candid sharing of the incredible challenges of trauma work and the opportunities for relational repair, provide much needed validation and support for trauma clinicians.

While clinical literature regarding working with trauma survivors exists, Kahn's detailed and authentic reflection on her career as a trauma therapist, brings to light many of the challenges that trauma clinicians are confronted with and may or may not voice or seek support around. Additionally, her ability to eloquently explain the challenges that have ultimately led to growth and insight for herself and her clients provides guidance and perhaps validation of the experiences of trauma therapists.

The utility of this book goes beyond the realm trauma intervention. While great value can be gained by professionals working with individuals and/or families impacted by childhood trauma, a more in depth and nuanced understanding of how childhood trauma may impact behavior, relationships, learning, and service engagement can inform direct practice, programs, and policies. Additionally, child trauma survivors could benefit from acknowledgement and validation of their experiences as well as insight into both the impact of childhood trauma and support needed to heal the early relational ruptures that continue to affect their overall well being.

Overall, *Baffled by Love*, seamlessly integrates research, practice, personal reflection, and the lived experiences of childhood trauma survivors which results in a powerful story of relational devastation and healing. The courage and vulnerability that is needed to engage in this difficult work is skillfully modeled by Kahn. Her willingness to share these transformative moments benefits both trauma professionals and trauma survivors.

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Mental Health on the Line: The Effect of Attachment Trauma on Immigrant Families Facing Separation or Deportation

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In the past decade, U.S. immigration policies have impacted the lives of immigrant families from Latinx countries. Recently, the "zero-tolerance" policy has enforced the criminal prosecution of adults illegally crossing the U.S. border, including parents and caregivers traveling with children (Department of Justice Office of Public Affairs, 2018). As a result, more than 2,600 children, some as young as 18 months (Kriel, 2018), have been forcibly separated from their families and placed in either the custody of a sponsor or held in a detention shelter (Valverde, 2018; Shapiro & Sharma, 2018). As of August 2018, 497 children (22 of whom are younger than 5) remain separated from their parents or caregivers and in federal shelters scattered throughout the U.S.- Mexico border (Shapiro & Sharma, 2018). Furthermore, immigration policies have affected thousands of children who are U.S. citizens. According to U.S. Immigration and Customs Enforcement fiscal reports, between 2015 and the end of 2017, a total of 87,351 parents were deported and subsequently separated from their U.S. citizen children (U.S. Department of Homeland Security, U.S. Immigration and Customs Enforcement [ICE] 2015a,b; ICE 2016a,b; ICE 2017a,b). The potential adverse consequences of recent immigration policies and enforcements on the well-being of children and adolescents are still not clear. Attachment trauma theory may explain the negative effects of forced separation and inform effective prevention and intervention efforts for vulnerable Latinx families.

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Separation, Deportation, and Attachment Trauma

Family separation and parental deportation can affect children's attachment systems. According to attachment theory (Bowlby, 1969), children's attachment systems develop in infancy and help them organize early relational experiences (Sroufe & Waters, 1977; Waters & Sroufe, 2017). The attachment system then becomes a guiding working model for their later interpersonal, emotional, and cognitive development (Kerig & Becker, 2010; Sroufe & Waters, 1977). This system also promotes children's survival by helping them cope with fearful and stressful situations (Bowlby, 1969; Bowlby,1973; Kobak, Cassidy, Zir, 2004). Specifically, this framework posits that attachment figures, often parents or guardians, facilitate coping with traumatic experiences and provide protection and comfort to their children. Thus, any real or perceived threat to the availability of an attachment figure, such as brief separation from a parent, constitutes a threat to children's survival and can result in fear, intense anxiety, and subsequent traumatic reactions (Bowlby, 1973; Kobak et al., 2004). These reactions are acutely more pronounced when children find themselves in unfamiliar environments or surrounded by strangers. Among adolescents., more extreme threats to the attachment figure, such as permanent separation, may also activate the attachment system and elicit fear and anxiety.

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Attachment theorists have posited that such activation of the attachment system may result in attachment trauma, which is conceptualized as the disruption of the attachment bond through forced separation of children from their attachment figures (Kobak et al., 2004). These separations are often prolonged, involve limited familial contact, and have no clear resolution (e.g., family reunification). Forced family separation and parental deportation are also likely to impact children's perceptions of their attachment figures' availability (Dreby, 2015; Gonzalez, 2015). Therefore, forced family separations occurring under current immigration policies may result in the activation of the attachment systems and subsequent attachment traumatization of thousands of young children and adolescents.

The Psychological and Behavioral Effects of Attachment Trauma

Attachment trauma as a result of forced family separation and parental deportation may derail the development of a healthy attachment system. A secure attachment system promotes healthy functioning and mental health among children (Ainsworth, 1979; Bowlby, 2008). Attachment trauma, however, is likely to decrease the likelihood of the emergence of a secure attachment and increase maladaptive attachment styles (e.g., anxious, avoidant, disorganized; Davies, 2011; Kobak et al., 2004). Furthermore, attachment trauma can result in a number of negative psychological and behavioral outcomes among children and adolescents. Although little is known about the effects of family separation, specifically for the families separated because of the "zero-tolerance" policy, literature on the forced detention of unaccompanied immigrant children from diverse countries suggests that these children have high rates of posttraumatic stress disorder (PTSD), anxiety, depression, and suicidal ideation (Baily et al., 2014; Teicher, 2018). Moreover, researchers have found elevated posttraumatic stress symptoms among Latinx children who have been forcibly separated from a caregiver through parental detention or deportation (Gonzalez, 2015; Rojas-Flores, Clements, Hwang-Koo, & London, 2017). Parental deportation has also been linked to increased anxiety and depression symptoms among children (Brabeck, Lykes, & Hunter, 2014; Dreby, 2012; Dreby, 2015). Notably, parental separation and deportation has been associated with high levels of teacher-reported externalizing behavior, and has contributed to higher rates of delinquency and substance use among children and adolescents (Rojas-Flores, et al., 2017; Rubens et al., 2013; McQueen, Getz, Bray, 2003). Thus, it is plausible that current immigration policies pose a substantial threat to children's psychological and behavioral well-being by precipitating attachment trauma.

Clinical Implications

Family reunification for separated families should be of highest priority given the adverse mental health outcomes linked to attachment disruptions. In the cases of many reunited families, treatment is essential in managing associated traumatic reactions (Zayas, Aguilar-Gaxiola, Yoon, & Rey, 2015). Accordingly, there is a need for trauma-informed, culturally-sensitive, evidence-based interventions for vulnerable children and families during the reunification process. Based on the attachment theory framework (Bowlby, 1973; Kobak

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et al., 2004), a key component for effective treatment following attachment disruption is to restore secure attachment by re-establishing the caregiver as available and trustworthy, thereby strengthening the parent-child relationship. For example, therapists may encourage the parent and child to share their emotions on the family separation or deportation during sessions in order to promote empathy and closeness in the relationship. Therapists may also encourage parents to identify their support networks, such as extended family, to help with parenting stress and family dysfunction that can result from the traumatic experience (Juffer, Bakermans-Kranenburg, van IJzendoorn, 2017). Further, culturally-appropriate interventions that center on Latinx values including family constructs (e.g., familismo, machismo, marianismo), interpersonal factors (e.g., personalismo, respeto, simpatía), and religious or folk beliefs (e.g., fatalísmo, espiritualismo) may also increase engagement in services among immigrant families (de Arellano, Danielson, & Felton, 2012; Rojas-Flores, et al., 2017).

Trauma-focused cognitive behavioral therapy (TF-CBT), an evidence-based treatment for children and adolescents with PTSD, has been culturally-adapted for Latinx families, and thus may be an appropriate intervention for reunified families (de Arellano, Danielson, & Felton, 2012). Developed by Cohen and Manarinno (2008), TF-CBT is a multicomponent treatment that equips families with psychoeducation, parenting strategies, and coping skills for continued stress management after a traumatic event. Psychoeducation is an ongoing process during which parents and caregivers are initially informed of the child's diagnosis and the TF-CBT treatment model. In later sessions, families are provided with information about the impact of trauma on children and family members, the nature of PTSD, and information to normalize the child's and parents' reactions. TF-CBT also equips caregivers with basic parenting strategies such as praise, selective attention (attending to the child's positive behaviors), appropriate time-out, and contingency reinforcement that may be individually tailored to each family to manage behaviors that may result from PTSD. Therapists also assist parents and children in gaining cognitive coping skills, including identifying thoughts related to upsetting events, determining the feelings and behaviors associated with those thoughts, and evaluating whether these thoughts are accurate and helpful. Conjoint parent and child sessions emphasize strengthening the parent-child relationship and processing experienced trauma by developing a narrative of traumatic events from the child's perspective and sharing it with his or her

parent. Each TF-CBT component can be individually tailored to specific traumatic events. In the case of family reunification, TF-CBT would address and manage traumatic reactions as a result of forced separation and parental deportation. Trauma-informed interventions with an explicit emphasis on cultural and contextual factors are needed to increase relevance, expand reach, and maximize benefits for Latinx immigrant families experiencing deportation or separation.

Policy Implications

Policy reform also may be leveraged to combat the adverse effects of forced family separation on immigrant families. Primarily, policy reform should emphasize the protection of children and families' rights during the immigration process to prevent forced separation (Brabeck et al., 2014). From a mental health services perspective, immigrant families need greater access to adequate mental health care. Moreover, there is a need for the reevaluation of immigration policies that have significant impact on access to mental health services in this population (Rodríguez, Young, & Wallace, 2015). An integrative care approach embedded within the immigration process may also increase accessibility of mental health services. Trauma-informed and culturally sensitive services and resources may be delivered to families at each level of contact throughout the immigration process by social workers, immigration workers, primary care physicians, legal and financial experts, and other professionals (Lustig et al., 2003). State-wide implementation of trauma-informed care and increased accessibility of services may be particularly impactful in states with higher rates of deportation (e.g., California, Texas). Previous research demonstrates TF-CBT can be scaled up and implemented in community settings (Webb, Grasso, Laurenceau, & Deblinger, 2014). Local, state-wide, and federal initiatives should further consider extending support for integrative systems of mental health care for separated families (Sigel, Benton, Lynch, & Kramer, 2013).

Conclusions

Recent immigration policies have negatively impacted the well-being of immigrant families by forcibly separating children from their parents. These forced family separations threaten perceived availability of attachment figures, are unplanned, and have no clear resolution. Attachment trauma perpetuated by forced family separation may result in the development of insecure attachment styles. Additionally, attachment trauma experienced by immigrant families may contribute to negative psychological (e.g., PTSD,
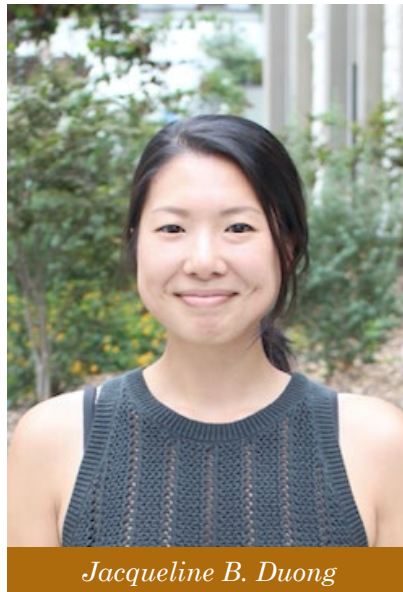
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anxiety, depression) and behavioral (e.g., delinquency, substance use) outcomes among children and adolescents. Increased accessibility for trauma-informed, culturally-sensitive, contextually relevant, evidence-based services may help ameliorate negative mental health consequences and unmet needs among immigrant families affected by immigration policies. Immigration policy reform should, first and foremost, focus on the protection of children and families' rights during the immigration process; and second, increase resources for mental health services to prevent attachment trauma and its debilitating sequelae (Brabeck et al., 2014).

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Cognitive-Behavioral Conjoint Therapy for Couples with Concurrent PTSD and Traumatic Bereavement Due to the Loss of a Child

Nicole Freeman-Favia, B.S., Mindy Merricle, Psy. M., & Jeremiah A. Schumm, Ph. D.

The following is a review of literature, focusing on Monson and Fredman's (2014) Cognitive-Behavioral Conjoint Therapy (CBCT) for Posttraumatic Stress Disorder (PTSD) and its possible utility with couples concurrently presenting with PTSD and bereavement due to traumatic loss of a child. Suicide-bereaved parents and parents who have lost children to other traumatic deaths, frequently experience traumatic grief and symptoms of PTSD (Albuquerque, Pereira, & Narciso, 2016; Murphy et al., 1999; Murphy et al., 2003; Swan & Scott, 2009). Traumatic loss of a child is unique from other traumas because it may involve a shared traumatic loss that is experienced by both parents. Other forms of trauma can impact both partners in a dyadic relationship, but they may not experience the interpersonal loss in the same way (e.g., a military member witnesses the death of a close friend in combat who is not well-known to the civilian partner). CBCT for PTSD has been developed to treat an individual for PTSD while incorporating a partner, significant other, or a close loved one. The incorporation of concerned significant other aids in the effectiveness in treating the individual with PTSD as well as improving relationship satisfaction between the dyad. The use of CBCT can be effective when one or both partners have PTSD. However, research is limited on couples in which both partners exhibit PTSD. In addition to addressing PTSD, this treatment may also lend itself to addressing traumatic grief identified in parents bereaved by violent child death (i.e., suicide, homicide, accident).

Nicole Freeman-Favia

Traumatic Loss of a Child

When a couple experiences the death of a child, the associated grief may be even more severe than when grieving other losses such as the death of a spouse (Sanders, 1980). This is especially true for parents bereaved by violent child death (i.e., suicide, homicide, accident). The sudden and catastrophic death of a child may lead to traumatic and complicated grief years after the loss (Rogers et al., 2008). A study from Ross, Kõlves, Kunde, and Leo (2018) examined suicide-bereaved

parents and their response to traumatic grief, as well as parents who experienced other forms of sudden or catastrophic death. Researchers gathered interview data over a year period from parents who had lost their children through a traumatic experience. Based on self-report from the participants, Ross et al. found that while maladaptive coping methods like avoidance and alcohol abuse occurred, there was also the potential for post-traumatic growth and strengthening of relationships. The data collected had no clear indication that the participants were seeking additional supportive counseling to address their feelings around their loss, but several indicated the benefit of support groups (Ross, Kõlves, Kunde & Leo, 2018). About 25 percent of mothers and 12 percent of fathers meet diagnostic criteria for PTSD five years after child death (Murphy et al., 1999; & Murphy et al., 2003). Conceptualizations of complicated grief and PTSD have shown several similarities including factors that maintain and exacerbate symptoms such as the inability to process loss into autobiographical memory, negative beliefs and interpretations of the grief, and avoidance of the loss (Boelen, van den Hout, & van den Bout, 2006).

With child loss, parents can experience their grief while also being affected by their partner's grief process. During such times, a couple often becomes disconnected from one another, and long-term grief becomes less manageable (McFarlane & Bookless, 2001). Similar to couples managing PTSD, bereaved parents may experience a decline in their relationship functioning (Albuquerque, Pereira, & Narciso, 2016). One study found that 12 percent of marriages end in divorce after the death of a child but also indicated that the death of the child might not have been the sole reason for divorce (The Compassionate Friends, 1999). Interventions including both parents can assess how the traumatic event has impacted their relationship regarding communication, sexuality, and intimacy (Albuquerque, Pereira, & Narciso, 2016; Amick-McMullan, Kilpatrick, & Resnick,1991; Barrera et al., 2009). When addressing PTSD in CBCT, communication and intimacy become target areas for change. These target areas are hypothesized to increase relationship satisfaction and reduce symptoms of PTSD (Monson & Fredman, 2012). We propose that CBCT for PTSD may similarly benefit couples experiencing
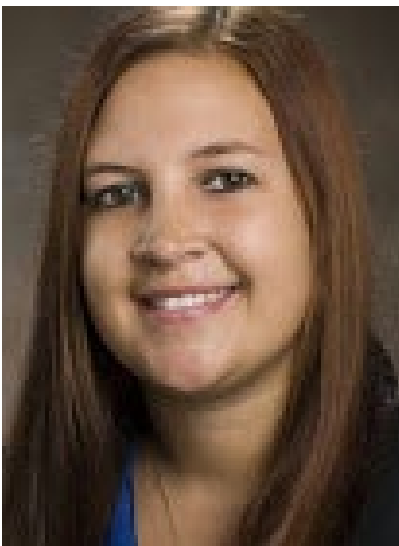
traumatic grief related to traumatic child loss impacting their relationship satisfaction.

Cognitive Behavioral Conjoint Therapy for PTSD

In addition to emotional, cognitive, and behavioral changes that occur when an individual develops PTSD, multiple studies show that higher levels of PTSD symptoms may be associated with worse intimate partner relationship functioning (Birkley, Eckhardt, & Dyskstra, 2016; Monson, Fredman, & Dekel, 2010; Taft, Watkins, Stafford, Street, & Monson, 2011). Research has suggested specific symptoms of PTSD impact relationship functioning. For example, emotional numbing has been found to be negatively correlated with relationship satisfaction and intimacy, while hyperarousal has a strong positive association with intimate partner aggression (Birkley, Eckhardt, & Dyskstra, 2016; Riggs, Byrne, Weathers, & Litz, 1998).

Mindy Merricle

CBCT is designed to target the symptoms of PTSD and improve relationship functioning with potential secondary benefits to reducing distress among concerned significant others (Monson & Fredman, 2012). This is accomplished by conducting conjoint structured sessions that focus on learning skills to improve positivity, manage conflict, improve communication, promote effective sharing of emotions and thoughts, increase problem solving, and promote changes in trauma-related cognitions. CBCT consists of 15 sessions that are broken into three stages. The first stage is focused on psychoeducation about PTSD and developing conflict management skills, which includes attention to avoiding aggression and promoting safety within the relationship. This stage is also designed to increase commitment to the conjoint therapy. The second stage incorporates behavioral interventions to increase positive behavioral exchange and to help improve communication skills between the dyad. Stage three focuses on cognitive interventions that begin addressing the maladaptive thinking patterns that maintain the PTSD symptoms and effect relationship functioning. Research on CBCT for PTSD has found that it is efficacious at reducing PTSD, unhelpful trauma-related cognitions, comorbid symptoms such as depression, anxiety, and anger, as well as improving intimate partner relationship

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functioning (Amick-McMullan, Kilpatrick, & Resnick, 1991; Barrera et al., 2009; Macdonald et al., 2016; & Monson et al., 2011).

CBCT for Violent Loss of a Child

Research on CBCT for PTSD has been conducted in couples with PTSD with one partner being diagnosed with PTSD or in mixed trauma samples, including those who have experienced combat-related trauma and interpersonal traumas such as sexual assault (Monson et al., 2012; Monson, Schnurr, Stevens, & Guthrie, 2004). CBCT with these populations focuses on education around PTSD, relationship satisfaction, and conflict management skills. Aspects of this approach can aide bereaved parents explicitly focusing on skills that may improve the relationship, emotional numbing, intimate aggression, and behavioral avoidance. Parents that have lost a child due to traumatic circumstances also report similar symptoms of PTSD and traumatic grief along with relationship disruption (Albuquerque, Pereira, & Narciso, 2016; McFarlane, & Bookless, 2001; Riggs, Byrne, Weathers, & Litz, 1998; & Swan, & Scott, 2009). Traumatic child death research suggests these conflicts and communication breakdowns can damage marital relations (Albuquerque, Pereira, & Narciso 2016; Oliver, 1999).

Although a traumatic death of a child may increase the risk for divorce and marital distress, there is also the potential for growth and strengthening of the relationship (Albuquerque, Pereira, & Narciso, 2016; Barrera et al., 2009; Murphy et al., 1999). CBCT for PTSD can be applied to couples experiencing traumatic loss of a child to foster increased feelings of connection and support and to help these couples to develop adaptive cognitions and behavioral coping strategies. Few services are available for bereaved parents and current options, such as support groups, may not help couples unable to adapt to new roles, fail to teach couples effective coping skills, or are not effective in improving their relationship functioning (Albuquerque, Pereira, & Narciso, 2016; & Barrera et al., 2009). CBCT for PTSD may be a viable option for helping parents who are struggling with symptoms of complicated grief and PTSD related to traumatic child loss.

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Mindy Merricle *is a fourth-year doctoral student at Wright State University School of Professional Psychology (SOPP). She is completing generalist training in her degree program at SOPP and is on track for graduation in 2020. Her early career goals consist of working within a Veteran's Affairs setting incorporating Veterans, their significant others, and families into treatment. Her clinical interest areas consist of the impact of posttraumatic stress disorder (PTSD), other significant traumas and mental health diagnoses on reintegration into civilian life after deployment.*

Dr. Jeremiah Schumm *is an Associate Professor in the Wright State University School of Professional Psychology (SOPP). He is a national trainer in cognitive-behavioral conjoint therapy (CBCT) for posttraumatic stress disorder (PTSD). He is primary developer of an integrated treatment that adapts CBCT for PTSD for treating individuals with co-occurring substance use disorders and PTSD. He has published 45 peer-reviewed journal articles and 12 book chapters. He serves on multiple journal editorial boards, including Psychological Trauma: Theory, Research, Practice, and Policy. Dr. Schumm also maintains an active private practice in which he utilizes CBCT for PTSD, along with a range of other empirically-supported treatments in treating individuals for PTSD.*
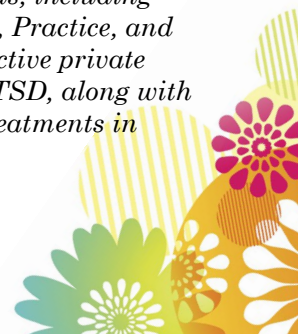
The NGO Committee on Mental Health in Consultative Relationship to the United Nations Trauma Working Group Annual Meeting: "The Fight for the Suffering Other"

Irit Felsen, PhD

This year's annual meeting of the Trauma Working group took place on February 14th and was entitled "The Fight for the Suffering "Other". The program provided a valuable opportunity to hear from colleagues who are directly involved in some of the most critical trauma-related topics of our time: the global refugee crisis, and the rise in discrimination and hate crimes in the USA since the 2016 presidential election.

Spyros D. Orfanos, PhD, ABPP, is Clinic Director of the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis, where he spearheaded the creation of the Immigration and Human Rights Work Group. Dr. Orfanos has partnered the Work Group with the NYU School of Law's Immigrant Rights Clinic and Physicians for Human Rights. Dr. Orfanos discussed immigration and displacement and the interface of psychoanalysis and human rights, and showed a short clip from the documentary "4.1 Miles," created by Daphne Matziaraki, which followed the action of a small Coast Guard boat during rescue-at-sea operations with refugees near the island of Lesbos.

Irit Felsen

Cindy Veldhuis, PhD. is a researcher at Columbia University and she participates in a cross-university collaboration between San Jose State University, University of Kentucky, and Columbia University that launched a national online survey aimed at understanding the impact of marriage equality and the 2016 elections on the health and well-being of those belonging to gender and sexual minorities. Dr. Veldhuis' findings show that the current political culture in the United States of emboldened expression of hate and discrimination has evoked strong reactions for many people, and that individuals who identify as non-sexually conforming expressed feeling at increased risk of experiencing discrimination and minority stress since the 2016 presidential election. The quantitative analysis of the findings reflected alarmingly elevated rates of exposure to discriminatory attitudes, hate speech and violence among the respondents since 2016.

The presentations by the two speakers at this year's Trauma Working Group meeting, the refugee crisis and the current socio-political climate in the USA, might seem like separate issues, but are also interrelated in many ways. Both speakers highlighted what amounts to a socio-cultural crisis and a critical time requiring an examination of the profound values of each of us individually, and of our society as a whole, with regard to our stance about the suffering Other. While refugees are the obvious "others", Dr. Veldhuis' research offers chilling evidence about the suffering of some individuals and groups who live among us and feel "othered" by political leaders, neighbors, or even family members. Some of the participants in the national survey reported that they chose to show their sexual preferences and sexual identity more openly, while others chose to "pass" as heterosexual, yet all experience the discriminatory attitudes and the dehumanization that they perceive around them.

We are all potentially "Other", more visibly, more obviously, or less so. Some of us have a choice about how much of their "Otherness" will be revealed, others are even more vulnerable, as they have less of a choice. As Dr. Veldhuis' findings show, as well as the data from the Antidefamation League which monitors hate crimes against Jewish institutions and individuals in the USA, our differences have become much more dangerous to show. It is perhaps even more painful to behold these negative trends because of the progress that has been achieved over the recent decades in legislation as well as in general social attitudes in the direction of greater social justice for all.

As the daughter of two Holocaust survivors I can attest to the piercing disappointment I feel when age-old antisemitic accusations are voiced in the political area as if no time has passed since the 1930's in Germany, or when violence against Jewish Institutions and individuals is reported almost regularly in the "Land of the Free and the Home of the Brave", to which some of my people and many other persecuted minorities fled from their homelands. The distinguished speaker, Dr. Orfanos, shared that he is the child of immigrants, as were my parents, who survived the horrendous Holocaust in Europe, and lost almost every single family member. My parents spent almost two years in Displaced Persons Camp, much like the refugee centers we see today all over the globe, housing thousands of

traumatized, uprooted people seeking a new home. My parents lost the future they were supposed to have and arrived penniless and without proper clothing in a new country, then-Palestine, right into another war.

Our different heritages of trauma must not be destructive, divisive forces, but must rather be channeled into empathy, social and political activism, and awareness to the suffering of others in our midst. Their pain calls for a response. Dr. Orfanos and his humanitarian work exemplify some of the ways in which we can use our professional expertise and foster collaborations with other professionals, to actively engage with massive social trauma. Dr. Veldhuis and her colleagues report that their participants found a way to support their hope and empowerment despite the fear of rollback of rights and in the face of rising threat of discrimination and hate. The participants, who represent some of the most vulnerable groups in the USA, felt that individual agency, recognition of support from others, and political engagement and collective action, helped them maintain their personal sense of hopefulness and feel empowered. These findings hold true for all of us, who feel discouraged by the

current political realities and socio-cultural climate. The NGO on Mental Health and the Trauma Working Group are always hoping to grow their membership and to be able to increase their influence by creating meaningful programs and making the meetings open to UN representatives and others. If you wish to join the Trauma Working Group, please contact the co-convener, Dr. Irit Felsen, at Irit.felsen@gmail.com or go to the website at https://www.ngomentalhealth.org/workinggroups/

Irit Felsen, Ph.D. is a clinical psychologist specializing in the treatment of trauma and traumatic loss. She is an Adjunct Professor at Yeshiva University and she maintains a private practice in NJ including individual and couple therapy. Dr. Felsen is co-convener of the Trauma Working Group of the NGO committee on Mental Health in Consultative relationship with the United Nations and a researcher with the Yale University Trauma Study Group, Genocide Studies Program. Dr. Felsen's interests are long-term effects of trauma on survivors, the impact of trauma on couple relationships, intergenerational transmission, and dehumanization in healthcare.

ANNOUNCEMENT

Refugee Mental Health Resource Network Database Report
An APA Interdivisional Project

Elizabeth Carll, PhD, Chair

The surge in crisis-affected migrants seeking asylum and refugee resettlement globally has demonstrated the increased need for mental health/psychosocial support. When the Refugee Mental Health Resource Network (RMHRN) and Database began development in 2016, we did not anticipate the great numbers of refugees that would be seeking asylum. This project began with an APA CODAPAR grant approved for 2017 and included Divisions 56, 35, 52, and 55, with other Divisions and state associations having joined as collaborators.

Currently, there are more than 550 volunteers in the database, which include licensed psychologists and mental health professionals, students interested in the training provided and psychologists interested in conducting research. If you are interested in volunteering to provide pro-bono services to refugee and immigrant children, adults, and families, please go to www.refugeementalhealthnet.org to join the Network.

To help prepare psychologists and mental health professionals to work with refugees, immigrants, and internally displaced people (IDPs), the Refugee Mental Health Resource Network has been developing a series of webinars. The RMHRN 11 webinars to date are listed below and others are being planned. Divison 56 Home

Study CE has been approved by APA, which will enable webinars to be viewed on demand, in addition to live. The Division 56 Webinar Committee, chaired by George Rhoades, is finalizing the software to implement the home study. Home Study CE will be available for all Division 56 webinars.

The Refugee Mental Health Resource Network Webinars offered between February 2017 and February 2019 are listed below and will soon be available on Home Study with APA CE .

- Screening and Intervening with Refugees; Understanding Trauma and the Mental Health Needs

- Conducting Asylum Evaluations

- Working with Interpreters with Refugee Populations in Healthcare Settings and for Asylum Evaluations

- Asylum Evaluations Continued: A More In-Depth Look at Evaluating Special Populations

- The Refugee Crisis: Understanding and Addressing the Mental Health Needs of Families and Children Displaced by Armed Conflict

- Beyond Asylum Evaluations: Conducting Immigration Evaluations for Cancelation of Deportation, Hardship Waivers, and Waivers from Taking the U.S. Citizenship Exam

- An Attorney's Perspective: Best Practices for Collaborating with Attorneys in Support of Immigrant Clients: Writing Effective Medical-Legal Affidavits; Testifying in Court and Understanding Asylum Law

- Vicarious Traumatization, Stress, and Psychological Resilience: Working with Refugee, Immigrant, and Internally Displaced Populations

- Understanding Differences Between Clinical Trauma Evaluations and Asylum Evaluations for Refugee and Immigration Requests

- Documenting, Report Writing and Expert Testimony in Asylum Cases: How to Effectively Integrate Information.

- What Happens When Someone is Deported? The Psychosocial Aftermath Experienced by those Deported

The webinars were developed in consultation with the Refugee Mental Health Resource Network Steering Committee. Since this is a multi-year initiative, the following names of the Steering Committee Members both current and former members since January 2017 to the present include: Chair, Dr.Elizabeth Carll; Members, Claudia Antuña; Carl Auerbach; Vivian Ballah-Swaray; Jean Lau Chin; Betsy Gard; Brigitte Khoury; Elaine LeVine; Diana Prescott; George Rhoades.

Association for Trauma Outreach and Prevention Mental Health Outreach Project to Nigeria and Niger Delta: Healing, Peace Building and Mindful Leadership

Dr. Ani Kalayjian

January 2019 – A call to responsible action

The Federal Republic of Nigeria, commonly referred to as Nigeria, is a federal republic in West Africa, bordering Niger in the north, Chad in the northeast, Cameroon in the east, and Benin in the west. Its coast in the south is located on the Gulf of Guinea in the Atlantic Ocean. The federation comprises 36 States and 1 Federal Capital Territory, where the capital Abuja is located. Nigeria is officially a democratic secular country, founded on October 01, 1960, with a population of 174.51 million (per 2013 reports) and GDP of 4397.47 Billion USD (per 2018 reports). Although English is the official language in the country, Nigeria's large population is responsible for its linguistic diversity which is like a microcosm of Africa as a whole.

Despite the efforts made by the Nigerian government and international groups, Nigeria is still in great need of emotional healing. The political conflict has been going on for over a decade. In November 2010 the federal government pledged to deploy more resources to the communities of the Niger Delta to boost development and help restore and sustain peace. The Niger Delta is a prominent region of the southern part of Nigeria. It is 70,00 square kilometers comprised of the following states: Delta, Bayelsa, Rivers, Akwa Ibom, Cross Rivers, as well as Edo, Abia, Imo and Ondo States. About one third of the land is made up of wetlands, swamp, mangrove forest and meandering waterways that stretch for 300 miles from the Benin River in the west to the Cross River in the east. It is Africa's largest Delta and the world's third largest mangrove (Taylor, 2007).

Violence Against Women & Political Unrest

Analyzing the genesis of modern-day brutality against people, especially women, in the Niger Delta area of Nigeria, scholars have pointed to the beginning of exploration and exploitation of oil in the area. According to these community the exploitation of oil resources in the Niger Delta has resulted in economic and environmental conflicts, with the women bearing the brunt of the situation. Studies have shown that oil provides over

90% of Nigeria's foreign exchange earnings, yet the people of the Niger Delta, especially the women are among the poorest in Nigeria.

Available evidence indicates that women in the Niger Delta area were subjected to all kinds of violence including sexual (i.e., rape), physical (i.e., beating, maiming and murder), and the destruction of property. They have suffered unimaginable human right abuses for which redress is unattainable because their husbands and sons have been killed or maimed in the conflict and women have had to assume burdensome responsibilities as heads of households (Akubor, Emmanuel;2011).

Urgent help in post trauma healing is needed in the Niger Delta area. Many residents of the region have been victimized and traumatized by the ongoing conflicts. While a lot of attention has been devoted to stabilizing oil production, little has been done to address the mental health needs of the residents of this region.

Nigerian Culture, Literacy, Health, Religion & Politics

Nigerian's culture is influenced by several different ethnic groups, who all determine the country's food, clothing, and overall culture. With around 250 ethnic groups, Nigeria has extensive and diverse list of traditions and customs. Education is extremely important and valued: adult literacy rate is 59.6% in 2015 up from 51.1% in 2008. Nigeria has one of the most complicated healthcare systems in Africa. Health standards, as measured by life expectancy, in Nigeria have increased since 1950, although progress has not been steady. Maternal mortality rate appears to have increased between 1990 and 2010. According to the latest World Health Organization (WHO, 2018) data, life expectancy in Nigeria is 54.7 years for men and 55.7 years of women with a total life expectancy of 55.2 years. This gives Nigeria a world life expectancy ranking of 178. Religion is an important phenomenon in contemporary Nigeria as it affects every segment of the Nigerian society. There are three primary religions in Nigeria: Christianity (53%), Islam (45%), and African Traditional Religion (2%).

Politically, Nigeria has 68 political parties with the most popular being the People's Democratic Party (PDP), the All Progressive Congress (APC), and the Social Democratic Party (SDP). The current President, Muhammadu Buhari (APC party affiliate) was reelected to a second term on February 23rd, 2019, after a contentious election in which the opposition refused to accept the outcome and a period of uncertainty and unrest that followed. With the opposition alleging fraud and refusing to accept the outcome, the risk of further unrest remains high in the weeks ahead, especially in the restive oil region, which was the scene of some of the worst election day unrest, according to King Agada IV (personal communication).

ATOP Meaningfulworld Goals

The Association for Trauma Outreach & Prevention (ATOP) Meaningfulworld (www.meaningfulworld.com) is an international charitable organization devoted to fostering a meaningful, peaceful, and just world. ATOP has planned a Mental Health Outreach Project (MHOP) to the Niger Delta region, set for the middle of June 2019. ATOP team members are trained in the 7-Step Integrative Healing Model, which will be implemented. Peace building and conflict transformation trainings are scheduled to take place at several universities, orphanages, older age homes, police, Ministries of Health, Education and Social Welfare, and other community centers.

Our goals are three pronged: 1. Healing and Education; 2. Research and Publications; 3. Policy Revisions and Developing Sustainable Programs. The following goals are established: 1. Healing groups; 2. Educational workshops on Emotional Intelligence and Post Trauma Healing; 3. Planting Trees and Nurturing Healthy Ecology; 4. Working with children, adolescents, adults, with men and women; 5. Establishing Peace & Forgiveness Gardens; 6. Transform Horizontal Violence and Generationally Transmitted Trauma; and 7. Share the 7-Step Integrative Healing Model.

Our Collaborators

Our collaborators are the University of Lagos, Department of Peace and Ethnic Studies, UN Agencies in Lagos, Centre for Human Development & Social Transformation (CHDST), Positive Change Alliance, a coalition of NGOs, as well as the King Agada IV, Ekpetiama Kingdom in Bayelsa State.

ATOP Meaningfulworld has spearheaded humanitarian missions in the past 30 years in over 46 countries and 25 States in USA, in response to both human-made and natural disasters. This humanitarian mission will be spearheaded by Dr. Kalayjian, Founder and President of ATOP Meaningfulworld. Volunteers are welcome, kindly email Dr Kalayjian: drkalayjian@meaningfulworld.com

Your Support is Appreciated

This mission, however, cannot be successful without your continued and generous support. The aftermath of trauma requires a long and challenging rehabilitation process. We appeal to you and express gratitude for your kind tax-deductible donation in providing psychosocial and spiritual help to the people of Nigeria, as well as the Niger Delta. Kindly send donations (**checks payable to ATOP**) or by PayPal at: http://meaningfulworld.com/get-involved/donation, www.meaningfulworld.com

Division 56 Fellows Committee

Hi All – It is an honor to Chair this important Fellows committee that has been Chaired by Laurie Pearlman for many years. Laurie, thanks for your service and helping so many of us achieve Fellow status in the Division.

I recently put together our new illustrious Committee: I am delighted to report that Charles Figley, who chaired the Committee at the inception of the Division, will continue on the committee. We have two new members, Melba Vasquez (Former APA President) and Bonnie Green (Professor Emeritus, Georgetown University Medical School).

Fellow status in APA is given to those who have made unusual and outstanding contributions to the field of trauma psychology. Their distinguished contributions are the foundation on which the future of trauma psychology builds. Fellows make on-going contributions to science, practice, and public policy through activities in this Division and in the field of psychology. Applications for fellow status are coordinated by the Fellows Committee.

Priscilla Dass-Brailsford

There are two types of Fellows Applications: Initial Fellows & Current Fellows

A. APA members who are not Fellows of any APA division must meet APA Initial Fellow criteria, apply for Fellow Status according to APA procedures, and complete forms via the APA application portal below.

http://www.apa.org/membership/Fellows/index.aspx.

In addition to meeting APA Fellow criteria, applicants must meet two or more of the specific Division 56 Fellow criteria, listed below.

1. Being a pioneer in the recognition and application of trauma psychology.

2. Making important contributions to the scholarly literature in the field of trauma psychology.

3. Producing consistently outstanding instructional or training programs that educate the next generation of trauma psychologists or developing important innovations in teaching or education in the field.

4. Demonstrating consistently outstanding clinical work with the traumatized as recognized by international or national groups through citations, awards, and other methods of recognition.

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

6. Demonstrating leadership in the area of trauma psychology across science, education, policy, and practice internationally and/or nationally.

*Division 56 requires that all new Fellow application materials (including three letters of recommendation from APA Fellows, at least one of whom must be a Division 56 Fellow) be submitted through the APA portal by **October 1, 2019**. This timeframe allows the Fellows committee to review all materials, make a recommendation, and forward completed application materials to APA in time to meet their deadline.*

B. If you are a current Fellow in another APA division, we ask that you write a letter describing the ways your work meets the above Division 56 Fellow criteria. We also ask for one (1) letter of recommendation from a current Division 56 Fellow (listed on our web site at http://www.apatraumadivision.org/honors.php).

Please submit these materials by e-mail directly to Priscilla Dass-Brailsford at pd227@georgetown.edu. We accept these applications on a rolling basis throughout the year.

We encourage all who are interested and qualified to apply! Although self-nominations are welcome, if you know of someone who qualifies for Fellow status please encourage them to apply. If you have any questions or need assistance with the application process please feel free to contact me directly.

Sincerely,

Priscilla Dass-Brailsford
pd227@georgetown.edu
Phone: 202-706 5078

Who's Who:
Bryann DeBeer

1) What is your current occupation?

I am a clinical research psychologist at the Veterans Affairs (VA) VISN 17 Center of Excellence for Research on Returning War Veterans. My research focuses on the intersection between trauma exposure and suicide risk. I examine novel mechanisms for suicide risk in trauma exposed veterans, with a particular emphasis on social risk factors. Then, I work to translate these factors into new interventions for suicide risk. I hold an appointment at Texas A&M Health Science Center at the rank of Assistant Professor.

I am also the Director of the VA Patient Safety Center of Inquiry - Suicide Prevention Collaborative, along with my colleague Dr. Justin Benzer who is an implementation scientist. Our center seeks to develop novel methods of suicide prevention for veterans who are not connected to VA healthcare, with a particular emphasis on leveraging implementation science in this endeavor.

2) Where were you educated?

I attended New York University for my undergraduate degree, where I majored in psychology and fine arts. I completed my doctoral training in clinical psychology at the University of Maryland, College Park.

3) Why did you choose this field?

After September 11th, 2001, several of my family members and friends enlisted in the military and were deployed to Iraq and/or Afghanistan. One of my friends was killed instantly when his Humvee ran over an improvised explosive device while serving in Iraq.

Bryann DeBeer

As trauma, PTSD, and suicide risk in our veterans became more widely recognized, I realized that I could use my skills to contribute to the knowledge base on these topics. I had an opportunity to start a career in VA conducting research, which I took, and now I've been doing this work for 7 years.

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

The most rewarding thing about this work is to be able to make a difference in so many lives. In research, you can both directly affect the lives of your participants and also the lives of many others through research findings.

5) What is most frustrating about your work?

I love when projects move quickly, however, that is often not the case in research. There are many setbacks and stumbling blocks. I started doing research in 2002 as an undergraduate and over the years I've learned to be positive and moving forward step by step to get the projects done.

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

I keep my life in balance by spending time with my family, hiking, traveling, cooking, and crafting.

7) What are your future plans

My future plans are to continue to conduct research on the intersection between trauma and suicide risk with the goal of improving the lives of veterans.

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.

Join Us

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

www.apa.org/divapp

*APA membership not required

Join Division 56 Today!

Register online at:
www.apa.org/divapp

Contact us via email:
division56membership@gmail.com

Membership Category	Rate	Journal
☐ APA Associate/Member/Fellow	$45.00	Included
☐ Professional Affiliate*	$45.00	Included
☐ Early Career Psychologist	$24.00 Renew $45	Included
☐ Student with Journal	$24.00 Renew $34	Included
☐ Student without Journal	Free Renew $10	No

List-Servs

Members can join our list-servs by e-mailing listserv@lists.apa.org and typing the following in the body of the note: subscribe div56

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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

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.

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

Editorial correspondence and submissions (< 3,000 words) are welcomed and appreciated. Please submit articles and references in APA style and send, via e-mail, as an attachment in Word format, to traumapsychologynews@gmail.com exactly as you wish it to appear. With their submissions, authors should also include a brief author statement, contact info, and photo at 300 dpi or at least 600 pixels wide by 900 pixels high.

PUBLICATION SCHEDULE

Issue	Submission Deadline	Publication Date
Summer	June 3	Late July
Fall	September 10	Late October
Spring	March 2	Late April

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

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

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

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

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