VOL 76
ISSUE 2
Spring
2023

THE CLINICAL PSYCHOLOGIST

A publication of the Society of Clinical Psychology (Division 12, APA)

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President Column

J. Kim Penberthy, PhD, ABPP

Dear Society of Clinical Psychology Members,

I hope you are enjoying the longer days and increasing sunlight as we move into the spring of 2023!

I am writing this month to provide additional information and updates regarding one priority for my presidency, which is to develop a strategic plan for SCP for the next three years. Strategic planning is important in any organization and plays an important role by providing a framework for setting goals and priorities, allocating resources and guiding decision making.

Specifically, I hope to use strategic planning to:

- (re)Define our mission and vision: clarify our purpose, identify values, and define long-term goals and objectives
- Identify strengths, weaknesses, opportunities, and threats: we can assess our internal and external environment, identifying threats and opportunities
- Set priorities and allocate resources: identify our most important goals and allocate resources to achieve them. We need to look at the future for our field and not just keep up, but get ahead and be leaders!
- Monitor progress and adjust course: track progress toward goals, identify areas where progress is lagging, and make corrective adjustments
- Foster collaboration and engagement: provide a shared understanding of the organizations' mission and goals and encourage participation from all sections, members, affiliates, advocates, and supporters!

ISSN 0009-9244

The SCP board held a preliminary strategic planning meeting lead by Dr. Michael Otto during our mid-winter board meeting that occurred in Nashville in early February 2023 and determined five areas for us to focus on. We thus developed five workgroups to collect information and pull together the issues, topics, questions and needs in these areas by early June 2023. These workgroups are led by your colleagues and associates and consist of a leader of the workgroup, an executive committee member liaison, and workgroup members from within and without the society. These workgroups are currently active and doing the important work of researching and developing the key areas for us to focus upon in our next three years. They are charged with researching and identifying these areas, developing strategies to address them, but not answering them – that work will be done by the strategic planning group and our society! I mention these individuals because I want to say thank you to these leaders and be very transparent with the society about the process. As such, I will share some of the details of our work for strategic planning.

The five workgroups are:

1. Clinical Psych Identity and Future - (board member responsible for launching the workgroup is Dr. Kim Penberthy and the lead for the workgroup is Dr. Danny Wedding)
2. Innovations & Products - (board member is Dr. Donna LaPaglia and lead is Dr. Amy Williams)
3. IDEAS: inclusion, diversity, equity, accessibility, sustainability - (board member is Dr. Kalyani Gopal and lead is Dr. Kenya Key)
4. Assessment and practice (board member Dr. Paul Arbisi and lead is Dr. Jordan Wright)
5. Marketing and Communications (board member Dr. Damian Grasso and lead is Dr. Gimel Rogers)

Ever since I joined SCP as a member decades ago, I wondered why our society did not have a conference of its own. I routinely attend other conferences relevant for clinical and health psychologists, such as APA, ABCT, ADAA, APAHC and have always thought that having our own conference would be a logical and worthwhile event.

Interestingly, it became clear during our preliminary strategic planning meeting that a Society of Clinical Psychology Conference would help address every one of the areas of concern in our strategic planning. Thus, I am happy to announce that we have decided as a board to hold our first SCP Conference! It will be in Atlanta, Georgia in conjunction with our midwinter board meeting in February, 2024. This will be our first division wide conference and we are thrilled with the idea of us all being together and celebrating all of our sections and the entire division! We already have co-chairs for the conference who are working hard to develop a committee. These co-chairs are Dr. Lily Brown and Dr. Richard LeBeau. More details will be forthcoming and we hope that if you have ideas and suggestions, you will reach out!

Your support and participation is important for the workgroups, the strategic planning and the proposed SCP conference! I want to keep our members informed and involved. If you wish to get involved in anything you read about in this letter and if you have any thoughts, ideas, feedback, please feel free to reach out to me!

Thank you for all you do,
Sincerely,
Kim

J. Kim Penberthy, PhD, ABPP

President, The Society of Clinical Psychology

SOCIETY OF
CLINICAL PSYCHOLOGY

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Positive Autobiographical Memories in the Context of Posttraumatic Stress Disorder

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Trauma is a common experience, with 90% of individuals in the United States and 70% of individuals across 24 countries reporting a traumatic experience in their lifetime (Benjet et al., 2015; Kilpatrick et al., 2013). Trauma exposure takes a toll on societies and individuals, leading to the development of posttraumatic stress disorder (PTSD) for a sizable minority of individuals (Magruder et al., 2017). PTSD is characterized by intrusive thoughts and trauma-related memories, avoidance of trauma-related triggers, maladaptive changes in thinking and affective processes, and alterations in arousal and reactivity (American Psychiatric Association, 2013). Substantial observational, experimental, and neurobiological research suggests that the experience of a trauma and PTSD entails disruptions in several aspects of both traumatic and positive autobiographical memories, including the capacity to learn information, the content of memories, as well as memory processes such as encoding, storage, and retrieval (e.g., Bomyea et al., 2017; Brewin & Holmes, 2003; Contractor et al., 2018; Kida, 2019; Ono et al., 2016; van Marle, 2015). As such, intervening on memory-related processes has been a key focus when treating PTSD.

Untreated PTSD has been linked to indicators of functional impairment and economic burden, such as social problems (e.g., difficulties in interpersonal relationships; Riggs et al., 1998), physical health problems (e.g., cardio-respiratory symptoms; Pacella et al., 2013), psychological problems (e.g., depression; Jacobson et al., 2001; Rytwinski et al., 2013), and financial costs to society (Kessler, 2000). Thus, providing effective preventive care and clinical interventions to individuals who are struggling with PTSD symptoms is imperative. Trauma-focused therapies, which are generally efficacious, are the gold standard treatment for PTSD (Schnurr, 2017). There is room for improvement, however, given 34-56% of trauma-focused treatment recipients do not experience remission following treatment (Cusack et al., 2016; Schnurr, 2017) and a substantial proportion of individuals discontinue treatment prematurely (Garcia et al., 2011; Hembree et al., 2003). Such treatment non-response and dropout may be attributed to memory-related processes, such as broader difficulties with trauma memory retrieval and the anticipated fear of anxiety-related sensations during exposure to trauma memories (Belleau et al., 2017; Leiner et al., 2012; Schottenbauer et al., 2008). Although modifying existing strategies (e.g., massed treatments for trauma-focused interventions) to increase successful engagement and retention in these trauma-focused treatments is critical, it is also important to consider novel strategies to address PTSD, in order to have a broader range of effective treatment options for trauma survivors. In this regard, a relatively unexplored and promising target is processing positive memories. In this manuscript, we will discuss evidence that supports addressing positive memories in PTSD interventions, as well as future directions for this line of work.

Why Should We Address Positive Autobiographical Memories in PTSD Interventions?

First, *positive* autobiographical memories have characteristics that individuals find appealing, valuable, and beneficial. Generally, positive memories are central to individuals' identities, life stories, and belief structures across cultures (Foley, 2018; Zaragoza Scherman et al., 2015a), are highly accessible and arise frequently (Walker et al., 2003; Williams et al., 2022), and are favored over time (Matlin & Stang, 1978). Further, retrieval of one positive memory increases the likelihood of retrieving other positive memories, and the affect experienced when recalling positive memories tends to remain for a substantial period of time (Ritchie et al., 2009; Williams et al., 2022). Thus, discussing positive memories in a therapeutic setting may be appealing and beneficial to clients.

Second, *trauma* survivors with PTSD symptoms experience difficulties retrieving both specific traumatic

and positive autobiographical memories. Indeed, a recently published scoping review concluded that individuals with PTSD generally retrieve fewer specific positive autobiographical memories compared to individuals without PTSD, and that individuals with experiences of childhood interpersonal traumas retrieve fewer specific positive autobiographical memories (Contractor, Caldas, Dolan, et al., 2022). Regarding PTSD symptom clusters, in a study of 203 trauma-exposed community participants, more PTSD symptom cluster severity (i.e., intrusions, negative alterations in cognitions/mood, and alterations in arousal and reactivity) was associated with fewer retrieved specific positive autobiographical memories (Contractor et al., 2019). Given this research, the question of concern is why do trauma survivors with PTSD symptoms have deficits with positive memory processes? Consistent with the scarring hypothesis (Williams et al., 2007), trauma memories and related negative content become central to trauma survivors' identities, and consequently, these individuals find it difficult to retrieve specific positive autobiographical memories and to integrate these memories with other lifetime memories (Bernsten & Rubin, 2007; Brewin et al., 2010; Brewin & Holmes, 2003). Additionally, these individuals may experience a wide range of negative emotions and less positive affect when reflecting on memories of past events (Clifford et al., 2020), may not be able to effectively regulate the positive emotions they experience when retrieving positive autobiographical memories (Contractor, Weiss, & Forkus, 2021), and may retrieve over-general memories of past events to cope with posttraumatic distress (Moore & Zoellner, 2007). Such patterns may contribute to less retrieval of specific positive autobiographical memories. Conversely, the vulnerability hypothesis suggests that difficulties retrieving specific positive autobiographical memories may increase the likelihood of experiencing distress after a trauma (Williams et al., 2007). Examples of such vulnerability factors include fewer pre-trauma positive experiences and their associated memories, and difficulties accessing pre-trauma positive memories (Bryant et al., 2007; Hauer et al., 2009). In sum, a variety of processes decrease the likelihood of trauma survivors with PTSD symptoms effectively retrieving and engaging with specific positive autobiographical memories, pointing to the necessity of intervening in this area.

Third, *cross sectional* evidence links positive autobiographical memory processes and characteristics to PTSD symptoms. For instance, in a sample of 185 trauma-exposed community participants, those with greater PTSD symptom severity reported less vividness of, less coherence of, less accessibility to, fewer temporal/sensory details of, and more distancing from retrieved positive memories (Dolan et al., 2020). Acknowledging the heterogeneity embedded in the construct of PTSD, we have also examined particular PTSD symptom clusters in relation to positive autobiographical memory processes and characteristics. In a community sample of 206 trauma-exposed individuals, those with more severe PTSD arousal symptoms reported fewer positive autobiographical memories, as well as less positive autobiographical memory coherence and accessibility; and those with more severe PTSD avoidance symptoms reported fewer positive autobiographical memories (Contractor, Greene, et al., 2020). Separately, those with more severe PTSD negative cognitions/mood symptoms and arousal symptoms reported less accessibility to positive autobiographical memories (Contractor et al., 2019). Such research is also supported by longitudinal evidence, which we elaborate below.

Lastly, observational and experimental longitudinal evidence links positive autobiographical memory processes and characteristics to PTSD symptoms. For instance, in a sample of 238 trauma-exposed students completing daily assessments for 10 days, there was a bidirectional relationship between PTSD symptom severity and positive memory characteristics. On days where students experienced more severe PTSD symptoms, their positive memories were less vivid and accessible, and vice versa (Contractor, Messman, et al., 2022). Interestingly, there were no lagged associations; PTSD symptom severity or positive memory vividness and accessibility reported on a prior day were not associated with positive memory vividness and accessibility or PTSD symptom severity, respectively, the following day (Contractor, Messman, et al., 2022). In a separate sample of 74 women reporting intimate partner violence and substance use, approximately 50% of the surveyed women with more severe PTSD symptoms reported less positive memory vividness and accessibility. Notably and not as expected, approximately 50% of the surveyed women with more severe PTSD symptoms reported more positive memory vividness and accessibility (Contractor, Natesan Batley, et al., in press).

In sum, cross-sectional and longitudinal research using diverse methodologies from our laboratory suggests that trauma survivors with PTSD symptoms report difficulties accessing and retrieving specific and detailed positive auto-biographical memories. However, there is some

Anne N. Banducci, PhD

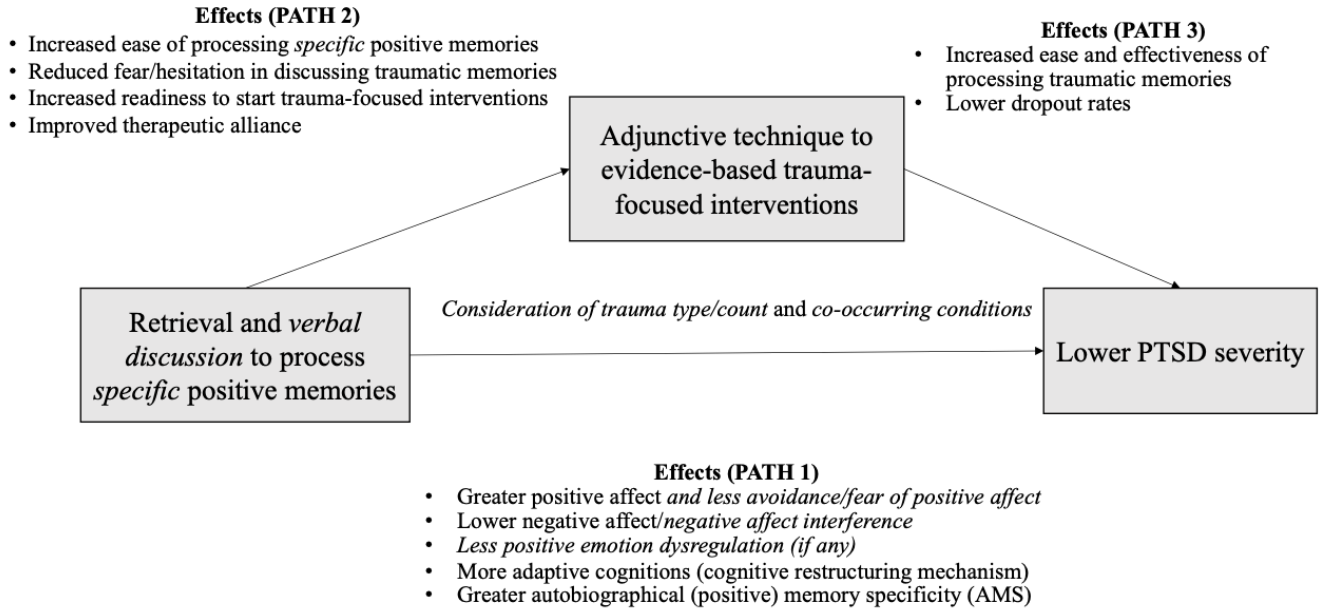
heterogeneity, wherein these patterns are not true for all trauma survivors. We have only examined a few contextual factors that explain this divergence. In this regard, our research suggests that presence of sleep disturbances as well as one's ability to regulate positive emotions may influence relations between PTSD symptoms and positive autobiographical memories (Contractor, Slavish, et al., 2021; Contractor, Weiss, & Forkus, 2021). Future research would benefit from exploring person-specific and environmental factors impacting the retrieval of positive memories in trauma survivors' daily lives and within therapeutic settings.

Positive Memory-PTSD Model and Processing of Positive Memories Technique for PTSD

Given the aforementioned research, our group has continued to explore why trauma survivors with PTSD symptoms have difficulties retrieving positive autobiographical memories and how we can intervene using positive memory processes as therapeutic targets, to expand our options for ameliorating PTSD symptomatology effectively. Such efforts led to the development of an overarching theory explaining these processes, the *Positive Memory PTSD Model*, as well as to the development of an intervention targeting these positive autobiographical memory processes, the Processing of Positive Memories Technique for PTSD.

The *Positive Memory PTSD Model* integrates findings from experimental evidence, memory intervention research, and positive psychology intervention research (Contractor, Banducci, et al., 2022; 2018). See Figure 1 for diagrammatic representation of the *Positive Memory PTSD Model*. Our model suggests that the retrieval and processing of specific positive memories may improve PTSD symptoms, affect, and beliefs, as well as facilitate benefits for subsequent trauma-focused treatments (e.g., enhanced readiness to start trauma-focused treatments, less likelihood of dropping out from trauma-focused treatments; Contractor et al., 2018). This *Positive Memory PTSD Model* spurred further research in the area of PTSD and positive memories, which was important because the majority of prior positive memory intervention work has been in the area of depression. Indeed, scoping reviews, systematic reviews, and meta-analyses demonstrate that positive memory processing generally has the greatest impact on improving positive affect and on reducing depressive symptoms (see Hitchcock et al., 2017; Miguel-Alvaro et al., 2021). Further, Hitchcock and colleagues' (2017) systematic review and meta-analysis found only one study focused on PTSD; the study compared a therapeutic technique addressing the retrieval of specific memories to a wait-list control, with results indicating larger decreases in PTSD symptoms in the intervention group. Hitchcock and colleagues (2017) concluded that while there is promising evidence for the beneficial impacts of

Figure 1. Updated Positive Memory-Posttraumatic Stress Disorder (PTSD) Model



Note. Italicized content indicates updates to the original Positive Memory-PTSD Model. This model is taken from Contractor, Banducci, et al. (2022).

memory-based interventions for depression, there is comparatively less research for PTSD, which hampers our ability to draw conclusions.

Drawing from the *Positive Memory PTSD Model*, we developed a novel 5-session *Processing of Positive Memories Techni ue* (PPMT), as a PTSD-specific intervention. This intervention aims to improve access to and the phenomenological quality of salient positive autobiographical memories, while capitalizing on the positive content from these memories (Contractor, Weiss, & Shea, 2021). PPMT was developed and refined using treatment development guidelines (Rounsaville et al., 2001) as well as stakeholder input from therapists (Contractor, Caldas, et al., 2020) and trauma survivors seeking therapeutic services (Banducci et al., in press; Caldas et al., 2020). The detailed session-by-session content of PPMT is outlined in Contractor, Weiss and Shea (2021). Briefly, in Session 1, individuals receive psychoeducation and an overview of PPMT's rational and goals, and are assessed for psychological symptoms. In Session 2, individuals recall one salient and meaningful positive autobiographical memory, narrate that positive autobiographical memory in detail, and process that positive memory to elicit values, affect, strengths, and thoughts (VAST) related to that memory to increase their salience to one's identity. Homework assignments include listening to an audio-recording of the narrated memory, completing a VAST log, and engaging in a values-consistent positive behavioral activity (e.g., spending time with family and friends). Engaging in positive behavioral activities may also help them create more positive memories. Sessions 3-5 involve the same procedure as Session 2; individuals process different positive autobiographical memories in each session. In Session 5, the therapist additionally reviews psychological symptoms and treatment progress. Individuals receiving PPMT improve in their ability to retrieve and process salient positive autobiographical memories over time, which helps them access/strengthen core positive values, affect, strengths, and thoughts (i.e., improving affective and cognitive processes), as well as increases awareness of positive information incompatible with trauma fear structures. Consequently, positive memories may replace trauma memories as reference points, influencing beliefs and life experiences. All such processes may contribute to improved PTSD symptoms (Contractor, Weiss, & Shea, 2021).

We conducted two pilot projects with PPMT. Using an experimental design, 65 trauma-exposed students were randomized to one of three conditions (narrating two specific positive autobiographical memories, writing about two specific positive autobiographical memories, a time-matched control) to determine the most effective strategy for processing positive memories, and to assess for the benefits of processing positive autobiographical memories. Students in the narrating condition reported significant decreases in PTSD symptom severity, negative post-trauma cognitions, and negative affect; as well as significant increases in positive affect across timepoints compared to those in the time-matched control condition (Contractor, Banducci, et al., 2020). Next, we piloted our PPMT intervention among 12 trauma-exposed individuals seeking services at a university psychology training clinic (Contractor, Jin, et al., in press; Contractor, Slavish, et al., in press). Using an idiographic statistical approach, we found the following: 9 participants reported statistically reliable changes for PTSD symptom severity (8 recovered/improved); 5 participants reported statistically reliable changes for positive affect levels (2 recovered/improved); 5 participants reported statistically reliable changes for positive emotion dysregulation (4 recovered); 9 participants reported statistically reliable changes for negative affect levels (8 recovered); and 9 participants reported statistically reliable changes for negative posttrauma cognitions (7 recovered/improved). These results suggest that PPMT differentially impacts varied posttrauma targets. For example, PPMT may help more with PTSD, negative affect, and negative posttrauma cognitions; and may have stronger effects on emotion regulation than on levels of positive affect.

In summary, PPMT, if supported in further clinical investigations, may add to the clinician's tool-box of PTSD interventions. To further gauge the impacts and benefits of PPMT, studies comparing PPMT to a control condition and with larger sample sizes of individuals diagnosed with PTSD is necessary. Emerging research suggests that targeting both positive and traumatic autobiographical memories improves PTSD symptoms (Hitchcock et al., 2017); with data suggesting that exclusively targeting positive autobiographical memories improves PTSD symptoms (Contractor, Banducci, et al., 2020; Miguel-Alvaro et al., 2021). Indeed, parallel to our work, Moradi and colleagues (2021) compared the effects of MemFlex (an intervention targeting the retrieval and elaboration of positive memories to improve individuals' abilities to move between specific and general levels of memory representation) to a control condition among 43 Iranian trauma survivors. They found lower PTSD symptom severity at follow-up in the MemFlex group compared to the control condition. Together, we can situate PPMT within the context of other positive psychology and memory-based interventions for posttrauma wellbeing,

Andrea Fentem, MA

with broader findings suggesting these interventions benefit trauma survivors reporting PTSD symptomatology.

Conclusions and Future Directions

Taken together, a robust body of work indicates that experiencing trauma not only impacts how traumatic memories are stored and retrieved, but also impacts the storage and retrieval of memories across the affective spectrum, including positive autobiographical memories. In this same vein, engaging with positive autobiographical memories, among trauma survivors, shares some of the same benefits of engaging with traumatic memories. Although this body of work is promising, there are a number of additional questions to consider and areas of exploration that we discuss below. We consider the generalizability and effectiveness of PPMT across a variety of populations, potential mediators and moderators, and outline next steps for this line of research.

First, based on clinical observations and research findings, there are critical points warranting additional investigation when *translating PPMT for use among individuals with diagnostic PTSD.* When we began doing this research, we did not expect that some individuals' difficulties engaging with traumatic autobiographical memories would be mirrored by the same level of difficulties engaging with positive autobiographical memories. Yet, in our PPMT pilot studies, we noticed that some trauma survivors found it extremely challenging to identify and recall a specific positive autobiographical memory that defined them, was meaningful to them, and related to their outlook on life (Banducci et al., in press; Fondren et al., 2022). These individuals also found it difficult to provide details of positive autobiographical memories (Fondren et al., 2022). We also found that even if trauma survivors were able to provide details of specific positive autobiographical memories, it was difficult for some of them to remain focused on positive aspects of their memories, to be non-judgmental of themselves or their experiences, to be fully engaged with their positive autobiographical memories, or to be comfortable with allowing themselves to have pleasant emotions and thoughts when discussing the memory (Fondren et al., 2022). Such processes could be even more challenging for individuals with diagnostic PTSD, paralleling difficulties retrieving traumatic memories observed in prior work. For example, trauma survivors, especially those with diagnostic PTSD, who experience dissociation also report broader difficulties with their memory recall (Özdemir et al., 2015). Given this, it is critical to test PPMT among individuals with more severe posttrauma symptomatology, so that we can examine their ability to engage effectively with PPMT and benefit from it, as well as to better understand how therapists can most effectively guide and engage these individuals through the intervention.

Second, *factors implicated in traumatic memory processes may also be relevant for positive autobiographical memories*. For example, sleep may impact consolidation of positive memories, given that it impacts this process for traumatic autobiographical memories (van Marle, 2015). Contextual and individual-level factors may also interface with the effects of PPMT. For instance, trauma and PTSD symptoms hamper neurocognitive abilities, such as attentional allocation, executive functioning, and memory processes (LaGarde et al., 2010), and these factors may impact positive memory retrieval in PPMT. It is possible that PTSD-specific symptoms may lead to difficulties with positive autobiographical memory retrieval; avoidance of trauma memories may generalize to avoidance of all past memories, negative alterations in mood and cognition may reduce the amount of pleasure experienced when thinking about positive autobiographical memories or may lead to beliefs about not deserving to feel good, and arousal symptoms may lead to physical sensations associated with happiness or excitement being experienced as aversive. Thus, further work is needed to understand how PTSD-specific symptoms versus broader difficulties with memory retrieval due to cognitive and other factors, may impact trauma survivors receiving PPMT.

Third, research needs to investigate the need and nature of *cultural adaptations of PPMT*. Indeed, memory function, content, and processes are shaped by cultural factors (Wang & Ross, 2007; Zaragoza Scherman et al., 2015b). For instance, individuals in collectivistic cultures are more likely to value and share positive autobiographical memories, which may then translate to collective memories that positively impact the community's identity (Reese & Fivush, 2008) and enhance emotional/social bonds (Wang, 2008). Indeed, individuals who identify as Asians tend to connect their life stories with that of the larger collective, in line with their collectivistic values (Wang, 2008); and often recall collective memories that involve social activities (Wang & Conway, 2004), which may help them cope with shared traumas (Wang, 2008). Thus, whether PPMT has differential impacts across a variety of cultural groups, or needs to be culturally-adapted and validated, is an important area of empirical investigation. This is especially important because positive autobiographical memories are central to individuals' identities and life stories across cultures (Zaragoza Scherman et al., 2015a) and represent culturally unbiased risk factors for PTSD (Jobson et al., 2016). Thus, positive memory processes may be a unique point of culturally responsive interventions.

Fourth, across our studies, *affect processes did not explain or influence the effects of retrieving positive*

autobiographical memories on posttrauma health (Contractor, Caldas, Banducci, et al., 2022; Contractor, Slavish, et al., in press), which is surprising given that we expected changes in affect to explain reductions in PTSD symptoms among trauma survivors receiving PPMT (see review by Contractor, Banducci, et al., 2022; Contractor et al., 2018). Interestingly, dysregulation of positive emotions has been shown to moderate relations between PTSD symptom severity and number of retrieved positive memories (Contractor, Weiss, & Forkus, 2021), such that more severe PTSD symptoms are associated with retrieving fewer positive autobiographical memories among trauma survivors who report positive emotion dysregulation. The question to investigate next is how different trauma survivors react affectively to retrieving and processing positive autobiographical memories in daily life, and whether facets of affect (e.g., arousal, valence, reactions to experiencing intense emotions) are relevant when considering who, or how trauma survivors, benefit from PPMT. Also, perhaps other mechanistic targets may explain the beneficial effects of PPMT, such as decreases in PTSD-related avoidance symptoms (Caldas et al., 2022).

Lastly, when considering how or why intervening on positive autobiographical memory processes benefits some individuals, it is helpful to consider learning processes. Research substantiates targeting the reconsolidation phase of traumatic memories to more effectively intervene on PTSD (e.g., blocking reconsolidation of the traumatic memory, facilitating fear memory extinction; weakening the traumatic memory by competition from other stimuli; Kida, 2019; Kindt & van Emmerik, 2016; van Marle, 2015). Much of this work has been conducted using conditioned fear models in animals, but there is evidence these processes are shared by humans. Recent work has demonstrated that activating a positive autobiographical memory during reconsolidation of a fear memory reduces conditioned fear acutely and enduringly (Grella et al., 2022). Although our paradigm does not focus on activating positive autobiographical memories during retrieval of traumatic memories, this work does demonstrate the power of positive autobiographical memories in disrupting traumatic memories, suggesting the utility of continuing down this path. Given that PPMT broadly evidences benefits for posttrauma health, it is worthwhile to examine how the retrieval of salient positive autobiographical memories interfaces with the reconsolidation of traumatic memories. Another aspect to consider is how the physical impacts of traumatic experiences may influence learning and thereby memory processes. Specifically, trauma survivors may experience head injuries, such as traumatic brain injuries or concussions, which can affect memory processes (Glaesser et al., 2004). These individuals may need alternative learning processes to encode and retrieve positive autobiographical memories.

Taken together, research suggest benefits to engaging with positive autobiographical memories among trauma survivors, whereas experimental, self-report, and longitudinal data demonstrates that individuals with more severe PTSD symptoms have difficulties with this very task. Whether these difficulties with memory retrieval differ among trauma-exposed and trauma-na ve populations, as a function of memory type (e.g., positive versus traumatic memories), is less understood. Indeed, we do not know who has difficulties engaging with positive autobiographical memories, or precisely why these difficulties are present. It is possible that pre-trauma factors like resilience, or having a more positive outlook impacts how trauma survivors engage with pleasant autobiographical memories. Separately, factors that make it difficult for some individuals to retrieve traumatic memories may also lead to difficulties retrieving positive memories (e.g., avoidance, cognitive factors). Looking forward, there are a number of important next steps to consider when implementing PPMT and making it scalable. We are eager to determine how and for whom PPMT will provide the greatest benefits in symptom reduction and for treatment engagement. Further, we need to determine the magnitude of the effects of PPMT among individuals with diagnostic PTSD, and whether PPMT may function effectively as a stand-alone treatment for some trauma survivors versus as an adjunctive pre-treatment intervention for others who also need trauma-focused interventions. Broadly, our research and clinical work lays the foundation for more work on positive autobiographical memories in the context of PTSD.

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Spring 2023 Diversity Spotlight

Interviewer: Esther Lapite, MA

Interviewee: Beverly Greene, PhD

The current spotlight focuses on the specific contributions of Dr. Beverly Greene, board-certified (ABPP) in Clinical Psychology and tenured Professor of psychology at St. John's University. She is a founding co-editor of the Journal of Critical Race and Ethnic Studies of the new Institute for Critical Race and Ethnic Studies of St. John's University. Her work focuses on psychotherapy with people who belong to marginalized and subordinate positions in the social hierarchy, and the psychological effects of social inequities such as heterosexism, sexism, and racism, as well as LGBTQIA+ psychology from an Intersectional identity and Black feminist lens. Dr. Greene earned her B.A. in Psychology from New York University in 1973 and received her M.A. and Ph.D. in Clinical Psychology from the Derner Institute of Adelphi University in 1977 and 1983, respectively. Dr Greene joined the faculty of St. John's in 1991after over a decade working in clinical public mental health with the NYC Board of Education, Brookdale and Kings County Hospitals Inpatient Child Psychiatry services in Brooklyn, NY, and Community Mental Health at UMDNJ in Newark, NJ.

With the tenacious encouragement and support of KCH Chief Psychologist Dr. Dorothy Gartner and peer mentors Laura Brown, Ellen Cole and Adrienne Smith, Dr. Greene initiated scholarly work to develop more intersectional paradigms in clinical approaches to treating clients from marginalized groups and to actively engage in training activities offering those perspectives. Moreover, she has worked to develop material dedicated to improving training for providers of psychological services for socially marginalized populations. Dr. Greene has authored over 100 publications, a dozen of which have received national awards for significant, distinguished, and pioneering contributions, and has conducted hundreds of professional presentations.

Dr. Greene continues to serve as a professor, scholar, and clinical psychologist, specializing in materializing oppressive ideologies within organized mental health. By focusing on the vulnerabilities of marginalized communities, Dr. Greene has led social justice efforts to expand the dominant cultural narrative in mental health to one that is more representative of and better represents the realities of the broad spectrum of human diversity.

Beverly Greene, PhD

Dr. Greene is the recipient of over 40 national awards for pioneering contributions that include APA's prestigious Senior Career Award for Distinguished Contributions to Psychology in the Public Interest, and two APA Presidential Citations citing her over 30 years of distinguished contributions to multicultural psychology and social justice, and as an early contributor to the concept of intersectionality that now dominates the field. A prolific scholar, her critical analyses of psychology combined with clinical acumen have made a tremendous impact on the greater integration of psychological practice and social justice. Her work challenges old paradigms and develops new psychological approaches that are more reflective of a diverse reality and that create a legacy to guide the future. Dr. Greene is a 2022 recipient of the Ackerman Institute for Family Therapy's annual Moving Families Forward Award. Her contributions are also featured on Mental Health America's 2021 website salute to Black Pioneers in Mental Health. Most recently, her notable expansion and critical research to the field of psychology and mental health counseling has resulted in her recognition from the Black Mental Health Graduate Academy. Given her outstanding contributions to the field, I posed the following questions to Dr. Greene and have included her responses below.

1) You continue to improve the treatment of African Americans and other marginalized communities and build cultural sensitivity among clinicians. When did you first develop this niche? Was there ever a moment in time that fueled this passion into a life-long dedicated career?

During my time in graduate school, I had initially prioritized my training in psychotherapy. During this experience, I noticed that there were a lot of people and their realistic circumstances that did not get discussed or integrated into a positive psychological perspective. I noticed that the field of psychology was alarmingly silent about the social contexts of people's lives and its bearing on their development, as well as how being required to manage social inequities like racism, sexism, and heterosexism contributed to mental health problems and complicated people's lives in ways that their individual efforts could not circumvent. I found while the absence of these considerations glaring, there was resistance to examining and incorporating them. My perception was that less than optimal services were being rendered to people who were members of these populations and that this reinforced a system that did not adequately treat nor understand individuals who were not a part of the dominant cultural mainstream.

My fellow students of color and later colleagues were aware of these omissions, and we often discussed this and would verbalize how the realities of racism were never integrated into the discussions of therapies with clients of color. Our field never highlighted how racism could affect the therapeutic dynamic when we knew perfectly well, from our personal and professional experiences that it did. At this point in time, I did not have the plan to write about it. Rather, I was attending conferences on the matter and connected with the Association for Women in Psychology during their convention in New York. The feminist therapy theoretical position was that the subordinate social status of women and the discrimination that was a part of that subordinate status contributed to mental health problems in women and should be incorporated into any psychotherapeutic attempt to appropriately contextualize and understand the lives of women in psychotherapies. This informed my thoughts that aspects of this model could be applied to other groups that were not being addressed in mainstream psychology. As a response, I started to discuss more about these things and do presentations. Subsequently, I was aggressively encouraged by feminist and LGBTQ scholars Laura Brown, Ellen Cole, and Adrienne Smith to write about the things I was discussing in presentations.

At that stage I began to focus on shaping those ideas into scholarly papers and found there was interest in that material. Other opportunities began to develop. This was not part of the grand scheme of my career plan, but I am in deep gratitude to those who pushed me in the direction that it evolved in, because I do not know if I would have done it otherwise. Sometimes people see things in you that you don't see in yourself. It's important to listen when people that you care about in respect are saying, “you know this really is something worthwhile you need to do this.”

2) The COVID-19 pandemic illustrated significant inequalities (in resources, communities affected, persons vaccinated, etc.), particularly among marginalized populations. How has the pandemic influenced your work on oppression and resilience?

The primary genre of my work has not shifted, but the recent season of police violence has encouraged me to focus on how the day-to-day life of parenting black children in climates of racial hostility and police violence affects mothers beyond superficial ways and to collect those narratives for publication. The panels with women who tell their stories and how they are affected are powerful testaments to the complexity of racial socialization and what the felt experience of that is like for mothers. The collection of narratives is called “Threading Needles in the Dark, Wearing Gloves: How Mothers of Black Children have the Talk then walk the walk. Considerations for Psychotherapy.” The panels are composed of a group of women telling their stories. I am focused on how this personally weighs on these mothers in ways that clinicians need to think about when they are working with these women. One thing that I continue to think about is a conversation I had with one of the participants. I asked her, “you know when you’re thinking about raising your children, what does it feel like?” She had told me, “Well it feels like I’m holding my breath, and I’ll breathe when I’m dead.” It's a powerful statement that I believe reflects what I am trying to materialize in this work, as well as many of my other works; I am trying to illuminate the everyday realities of social oppression. I am also trying to look at what these thoughts and experiences do to people in terms of how they have to navigate and think about mundane and extreme life situations from positions of vulnerability and resilience. I believe that there is a story behind these experiences, and these stories need to be told, to promote better understandings of their dilemmas, particularly therapists.

3) You have provided significant efforts to dismantle sexist and racist oppressions in the field of clinical psychology. What additional contributions do you think rising clinicians and scholars should address in our current socio-political climate?

While I do believe that we have made progress, I am still having some of the same conversations I was having 30 years ago about the realities of racism and incorporating an understanding of the psychological work involved in navigating social inequity into psychotherapies. I still find students and therapists struggle with how to navigate the issue and how to discuss it with patients. A colleague, Kirkland Vaughans, the founding editor of the Journal of Infant Child and Adolescent psychotherapy and an analyst here in New York City, once said “you know race has this power to make people so anxious that they lose the capacity to think.” Hopefully the more we can have these discussions the more we can facilitate greater competence in our profession when it comes to understanding racialized aspects of clients experiences.

4) Your esteemed contributions continue to impact experts and developing professionals alike. What impact can the world expect from you next, Dr. Greene?

In addition to Threading Needles, I am working on another book titled “The Rainbow that never was: Liberation Psychotherapy with LGBT POC” with Marie Miville and Angela Ferguson for the Division 44 book series. It is about the practice of liberation

psychotherapy with LGBTQ+ POC.

Outside of those works in progress, I have a lot of ideas and topics of interest. However, these things take a lot of time, and as a full-time professor, I often have limited availability to develop these ideas to fruition. I hope that developing professionals can help continue this line of work, especially when it pertains to the social oppressions of many people with minority sexual orientations, gender diversity, ethno- racial identities, and other socially marginalized populations.

Written by Esther Lapite, MA

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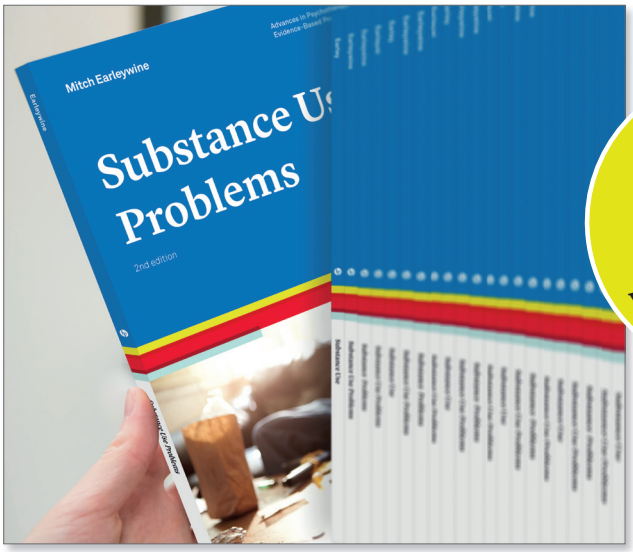

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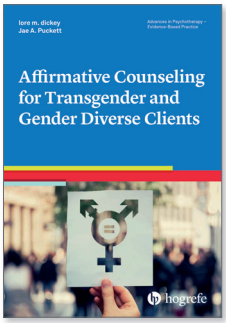

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Vol. 45, 2023, vi + 104 pp.
ISBN 978-0-88937-513-0
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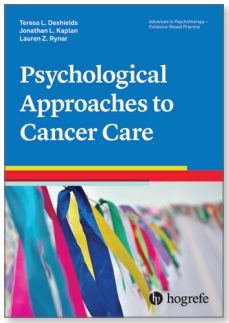
This volume presents fundamental and evidence-based information on working with transgender and gender diverse people in mental health services. The authors outline the key qualities of affirming mental health services and explore strategies for improving inclusivity and evidence-based care with trans clients. Current topics, such as working with youth, the harmful and ill-advised approach known as rapid onset gender dysphoria, and whether and how autism might be a co-occurring diagnostic concern are also addressed.

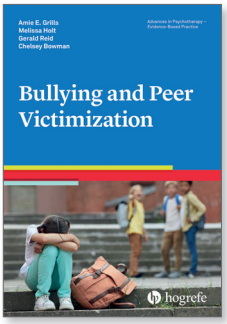


Teresa L. Deshields / Jonathan L. Kaplan / Lauren Z. Rynar

Psychological Approaches to Cancer Care

Vol. 46, 2023, vi + 86 pp.
ISBN 978-0-88937-511-6
Also available as eBook

This volume provides psychologists, physicians, and other health care providers with practical and evidence-based guidance on the delivery of psychological interventions to patients with cancer. The authors succinctly present the key principles, history, and theoretical models of cancer-related distress, as well as explore clinical assessment and interventions in cancer care. In addition, they look at multidisciplinary care management and complementary supportive interventions.

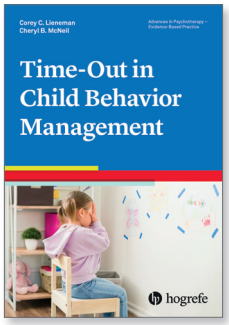


Amie E. Grills / Melissa Holt / Gerald Reid / Chelsey Bowman

Bullying and Peer Victimization

Vol. 47, 2022, viii + 72 pp.
ISBN 978-0-88937-408-9
Also available as eBook

This volume provides clinicians with clear guidance on how to assess and treat this complex behavior. Practitioners learn about what bullying is, its prevalence, how cyberbullying differs from in-person bullying, and what models are available for understanding how bullying occurs. The reader is guided through the most effective school-based prevention programs that aim to reduce bullying. A clinical vignette gives hands-on insight into how a bullying case in a school is managed.



New

Corey C. Lieneman / Cheryl B. McNeil

Time-Out in Child Behavior Management

Vol. 48, 2023, x + 116 pp.
ISBN 978-0-88937-509-3
Also available as eBook

This is a comprehensive guide to understanding, administering, and teaching caregivers to implement time-out effectively for child behavior management. Practitioners will appreciate the focus on applied research highlighting the efficacy of specific time-out parameters and the overviews of behavioral parent training programs that include time-out. Readers learn about the use of time-out in parent–child interaction therapy, both conceptually and through an in-depth case study. Includes downloadable tools.

Order and price information

The volumes may be purchased individually or by Series Standing Order (minimum of 4 successive volumes). The advantages of ordering by Series Standing Order: You will receive each volume automatically as soon as it is released, and only pay the special Series Standing Order price of $24.80 – saving $5.00 compared to the single-volume price of $29.80.

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Emotional Processing Scale

The *Emotional Processing Scale (EPS)* is a short online questionnaire designed to identify emotional processing styles and potential deficits. The EPS is for use by clinicians working in mental health, psychological therapy and health psychology, as well as researchers interested in the emotional life of healthy individuals and other populations.

The EPS can be used to:
- identify and quantify healthy and unhealthy styles of emotional processing;
- assess the contribution of poor emotional processing to physical, psychosomatic and psychological disorders;
- provide a non-diagnostic framework to assess patients for research or therapy;
- measure changes in emotions during therapy/counselling;
- and assist therapists in incorporating an emotional component into their formulations of psychological therapy.

The EPS provides the individual with a series of 25 statements to rate as to their applicability of how they felt or acted during the last week. The EPS uses five subscales (Suppression, Signs of unprocessed emotion, Controllability of emotion, Avoidance, and Emotional experience) to generate a total emotional processing score.

To learn more or use the EPS online with your clients, please contact us at
customersupport@hogrefe.com