

Concurrent Session 1
Thursday, November 13
8:00 a.m. – 9:15 a.m.

Ghosts and Angels in the Nursery: Curtailing the Transmission of Trauma From Parents to Children
(Abstract #198318)

Master (Child, Clin Res) State Ballroom, 4th Floor

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There is empirical evidence that children aged birth—five become traumatized by exposure to repeated family and community violence and show developmentally specific manifestations of traumatic stress. Early trauma treatment presents special challenges because the child's traumatic stress is compounded by the parents' traumatic response. This presentation will describe the manifestations of traumatic stress in infants, toddlers and preschoolers and the intergenerational transmission of traumatic stress from parent to child. It will also describe Child-Parent Psychotherapy (CPP), a relationship-based treatment where parents' unresolved traumatic experiences are integrated with their experiences of feeling safe and protected to generate adaptive parenting strategies that promote the child's attachment security and emotional health. The presentation will include CPP theoretical background, clinical modalities, and case illustrations, as well as empirical evidence of efficacy from randomized controlled trials. Cultural considerations in the treatment of children and families from diverse ethnic, racial, and socioeconomic backgrounds will be discussed.

ISTSS on Sesame Street: Helping Military Families Cope With Deployment and War Injury

(Abstract #195853)

Media Presentation Crystal Room, 3rd Floor

Kudler, Harold, MD¹; Fried, Hedi, PhD²; Albeck, Joseph, MD³;
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When a soldier is wounded, a family is wounded. Over a million children in the United States have had at least one parent deploy for military service in Afghanistan or Iraq. To reach out to these families, Sesame Workshop brought together writers, artists, producers, clinicians, researchers, educators and others to produce "Talk, Listen, Connect." Best known for their Muppet characters, Sesame Workshop promotes its curricula to children, parents, and professionals. In TLC I (available at <http://www.sesameworkshop.org/tlc/>) Elmo's father is going away and Elmo and his family must cope with the long separation and uncertainty of deployment. TLC II shows what happens when a parent comes home with wounds, visible and invisible. It is designed to break the silence that often separates trauma survivors from family members. This media panel, a presentation of the Special Interest Group on Intergenerational Transmission of Trauma and Resilience, includes a screening of TLC II followed by discussion by an expert panel regarding three key questions: --(1) Does TLC II accurately reflect responses to a parent's traumatic experience and its aftermath?: (2) Can it be expected to diminish the impact of trauma on the individual and the family?: and (3) Can it help increase that family's resilience?

New Directions in Neuroimaging Studies of PTSD

(Abstract #195997)

Symposium/Panel (Bio Med, Res Meth) Grand Ballroom, 4th Floor

McFarlane, Sandy, MD¹; Moore, Kathryn, PhD²; Clark, Richard, PhD²; Lanius, Ruth, MD, PhD³; Bluhm, Robyn, PhD³; Williamson, Peter, MD, DpsY³; Osuch, Elizabeth, MD³; Boksman, Kristine, PhD⁴; Stevens, Todd, MSc⁵; Brewin, Chris, PhD⁶; Whalley, Matthew G., PhD⁶; Kroes, Marijn, MSc⁷; Vermetten, Eric, MD⁸

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The symposium includes descriptions of specific networks that function abnormally in PTSD, using this to advance theoretical understanding of the disorder. Also described are the neural processes implicated in reliving, a core symptom of PTSD. A variety of new techniques, many involving neural feedback, offer opportunities for advancing PTSD treatment.

Working Memory and PTSD: A Neural Network Model of PTSD

This paper will present a neural network model of PTSD, based on the body of neuroimaging research that has investigated the processing of neutral and traumatic stimuli in PTSD. We propose that the primary abnormality in PTSD is a premature recruitment of networks that are typically associated with high demand tasks at much lower orders of challenge. This means that in this disorder there is a limited resource to deal with the information processing demand of complex environments. This limitation may account for the inability to process the memory of the trauma and account for many of the subjective experiences associated with this disorder. From our fMRI work the critical regions in this abnormal premature recruitment are the bilateral dorsolateral prefrontal cortex and inferior parietal lobule. Similarly, in higher demand tasks, PTSD sufferers fail to activate the hippocampus, anterior cingulate, and brain stem pons, key regions implicated in the neurobiology of PTSD. The functional connectivity studies provide valuable insights into the reciprocal networks which underpin the differences between PTSD patients and controls, and highlight the compensatory systems which sufferers with this disorder utilise to maintain and engage with their environment.

"Default Network" Abnormalities in PTSD: A fMRI Investigation

Recent neuroimaging work in healthy controls has shown the existence of a "default network" of correlated brain regions active during rest. These regions, which include the posterior cingulate, anterior cingulate and medial prefrontal cortex, and lateral parietal areas, have also been implicated in self-reflection. This study investigated whether (1) there are abnormalities in the default network in PTSD patients and (2) the extent of these abnormalities correlates with clinical measures of PTSD and dissociation. Resting state fMRI scans were obtained from seventeen healthy controls and seventeen patients with PTSD. Connectivity between the posterior cingulate and other brain areas was assessed. In healthy controls, activity in the posterior cingulate seed region was found to positively correlate with other regions of the default network. This correlation was reduced or absent in the PTSD group. Connectivity of the posterior cingulate with regions of the default network was modulated in the PTSD group by scores on the Clinician Administered PTSD Scale (CAPS) and on the Dissociative Experiences Scale. These results suggest that the integrity of the default network is compromised in PTSD and that

the extent of the deficit reflects clinical measures of PTSD as well as those of altered self perception.

Neural Correlates of Reliving in PTSD

The study was designed to investigate hypotheses about neural differences supporting flashbacks versus ordinary autobiographical memories of trauma in patients with PTSD. Twelve patients wrote in detail about their trauma and then segmented the narratives into reliving and ordinary memory sections. Words and phrases from each of these sections were selected and matched on word length and frequency, then presented within an fMRI scanner in the context of a recognition task. Distractor items were reliving and ordinary memory words and phrases from another patient's narrative. Emotion and arousal ratings for each item were collected post-scan. We will report analyses comparing neural responses to the four sets of words and phrases, as well as responses to reliving episodes experienced spontaneously within the scanner.

Regulation of Brain Activity in PTSD

The field of applied neuroimaging in PTSD is taking rapid advantage of the opportunities that are provided by technology. These relate to PET as well as fMRI findings and range from dissociative processing and pain perception to receptor imaging and cortical thickness measurement. In this presentation a review and update is provided of these studies. The focus will be on methods, such as those used in brain gaming tools, that feed brain information back to the patient. One such method that is already seen in various treatment settings is alpha/theta training. Although little information has so far had an impact on the PTSD field, clinicians need to keep pace with the new opportunities that are becoming available. Some caution is needed before these strategies can be implemented routinely in therapeutic practice, but their strengths may be considerable. For example, virtual reality exposure within a laboratory setting may soon lend itself to a phase oriented treatment approach. This may be especially relevant for those populations in which an instrumental solution is preferred, timed in the early phase of treatment, to increase a sense of efficacy in a safe manner. Pro and cons of current applied neuroimaging opportunities will be discussed.

Dissemination of Two Evidence-Based PTSD Treatments in the Veterans Health Administration

(Abstract #196054)

Symposium/Panel (Media Ed, Practice) Adams Ballroom, 6th Floor

Resick, Patricia, PhD¹; Foa, Edna, PhD²; Ruzek, Josef, PhD³; Karlin, Bradley, PhD⁴; Artz, Caroline, BA¹; Eftekhari, Afsoon, PhD²; Hembree, Elizabeth, PhD²; Kelly, Kacie, MHS¹; Lester, Kristin, PhD¹; Monson, Candice, PhD¹; Ready, C. Beth, PhD¹

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To ensure best care for veterans, VA's Office of Mental Health Services has initiated national training programs designed to increase delivery of two evidence-based PTSD treatments: Cognitive Processing Therapy and Prolonged Exposure. Design and implementation of these large-scale dissemination initiatives, their impact to date, and lessons learned will be described.

Disseminating Cognitive Processing Therapy in VA: The Advantages and Challenges of a National Training Initiative

With the goal of bringing evidence-based treatments into practice settings serving veterans, VA Office of Mental Health Services began funding a national initiative to disseminate cognitive processing therapy (CPT) in 2006. Phase 1 was devoted to developing training materials specific for use with veteran and military patients (CPT therapist manual), developing workshop and

case consultation materials, and training a cadre of trainers for Phase 2. Phase 2 consisted of 22 CPT training workshops conducted in each region of the country (845 participants), conducted between July 2007 and April 2008 followed by the availability of telephone case consultation. Obtaining the buy-in from administrators at all levels of VA was an important component of the roll-out. Phase 2 included development of a website with downloadable material, an interactive calendar, and discussion board. In late 2007, advanced tutorials were added, provided over teleconference with accompanying slides. Phase 3 will provide more basic workshops, advanced workshops and training in group CPT. Furthermore, facilitators at each hospital will be identified and trained to localize the training/supervision and work on implementation issues in their hospitals. This talk will include the formative process, accomplishments, barriers, and lessons learned in large-scale dissemination.

Disseminating Prolonged Exposure Therapy (PE) in VA: Challenges, Barrier, and Successes

Recently there has been increased recognition of the urgent need to disseminate evidence-based treatments for psychiatric disorders, to provide mental health patients served in community settings with the most efficacious treatments. to bring evidence-based treatments to veterans with PTSD, VA Office of Mental Health Services began funding a national initiative to disseminate Prolonged Exposure Therapy (PE) in 2007. In this presentation we first provide a brief overview of PE and its two main components: revisiting and recounting the traumatic memory (i.e., imaginal exposure) and gradual confrontation with trauma-related situations (i.e., in vivo exposure). We will then describe three components of the dissemination initiative. The first involves eight 4-day workshops in which 200-300 VA therapists are being trained to conduct PE, along with close supervision on their first patients to ensure accurate implementation of PE. The second component comprises three 5-day workshops in which 45 experienced VA PE therapists are taught to supervise newly trained clinicians. The third component is a three-day workshop preparing 15 PE supervisors to become PE trainers. We will discuss the development of training materials, the structure of VA training/supervision, experiences with training/supervision to date, and comparisons with previous PE dissemination initiatives.

Bringing Prolonged Exposure Treatment Into the Real-World of VA PTSD Care

Any effort to disseminate evidence-based treatments must address the challenges and opportunities related to bringing a specific treatment into a specific real-world service environment. Based on continuing assessment of a range of barriers and facilitators to dissemination of Prolonged Exposure Therapy for PTSD within the Veterans Health Administration, an ongoing national training program is described that includes features designed to address the multiple systemic, practitioner, and patient factors affecting the adoption of this treatment. Since September 2007, during the first phase of implementation, approximately 180 clinicians have received training in delivery of PE, and another 35 individuals have been trained and begun to provide individualized clinical consultation for trainees. Ongoing efforts to work with organizational leadership to address systems issues, to "market" the treatment to clinicians and treatment program managers, to create a WEB-facilitated community of PE practitioners, to enlist support from key decision-makers, and to implement a program evaluation system designed to inform the dissemination initiative are described, along with anticipated ways of addressing continuing challenges.

Integrating Spirituality in Training and Care

(Abstract #196089)

Symposium/Panel (Cul Div, Practice)

Salon 2, 3rd Floor

Lyons, Judith A., PhD¹; Eriksson, Cynthia B., PhD²; Drescher, Kent D., PhD³; David, Foy W., PhD⁴

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Faith is often a major component in trauma recovery. Recovery can be complicated when acts of terror are linked to religious ideology. This panel addresses challenges encountered in conceptual integration of spirituality in clinical training and trauma care. Diversity among therapists, trainees, individual clients and group members is discussed.

Honoring Diversity of Beliefs in Group Therapy in an Academic Setting: Decision Points

Addressing spiritual conflicts and beliefs within a therapy group can be a challenging task, particularly when there is a homogeneous majority plus a minority with divergent beliefs. Operating within a governmental academic setting in which trainees come from a different belief background than most patients adds an additional degree of difficulty. The emergence of a patient-initiated religious ritual within VA therapy groups will be examined to illustrate several of the clinical and administrative decision points involved. Efforts to balance majority and minority viewpoints, evaluate contrasting needs of patients and trainees, and reframe disagreements as opportunities for practice in reconciliation and conflict management will be critiqued. [Lyons]

Religion as a Barrier and Resource in Trauma Treatment

Survivors of traumatic events hold a diversity of perspectives on faith and religion. A brief review of research on trauma and spirituality demonstrates the complexity of spiritual and religious variables in relation to traumatic exposure and distress. These religious experiences, beliefs, and values may become both barriers and resources in trauma treatment. The model of creating a spiritual narrative (Wilson & Moran, 1998) offers a framework for ethical dialogue with clients regarding their religious histories and practices. Case examples of survivors of rape and other acts of terror will be used to operationalize the development of a spiritual narrative. These cases will also demonstrate the ways that personal religious beliefs, historical religious values, and faith-oriented practices are embedded in a trauma recovery process. [Eriksson]

Spiritual/Moral Challenges of Combat: Helping Military Service Members Make Meaning of War Traumas

Spirituality may enhance resilience by buffering adverse psychological effects of combat; or it may be changed in a negative direction, becoming a casualty of war itself. The authors will describe their recent experiences in training active duty military chaplains, mental health specialists, physicians and nurses to identify "moral injuries" commonly reported by combat veterans. Four spiritual "red flags"-loss of faith, negative religious coping, guilt, and lack of forgiveness- are common reactions among combat soldiers that military care-givers need to recognize and be able to provide support as service members grapple with these formidable spiritual challenges. Evolution of a group therapy format to help veterans address their spiritual challenges and make meaning of their combat experiences in their daily lives will be described. [Drescher & Foy]

Social and Cognitive Determinants of Recovery After Trauma

(Abstract #196118)

Symposium/Panel (Clin Res, Prev EI)

Wabash Room, 3rd Floor

Littleton, Heather L., PhD¹; Cieslak, Roman, PhD²; Benight, Charles C., PhD³; Nuttman-Shwartz, Orit, PhD⁴; Dekel, Rachel, PhD⁵; Lauterbach, Dean, PhD⁶; Mason, Shawn T., PhD⁷; Fauerbach, James A., PhD⁸

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Social cognitive theory encompasses both individual and social/environmental factors in predicting human behavior. This symposium will review several studies that have focused on the interactions between intra-individual and social/environmental factors involved in trauma recovery.

Social Support and Sexual Assault Recovery: The Mediating Role of Coping

Social support following trauma, such as sexual assault, has been conceptualized as facilitating recovery, in part through influencing trauma-related coping. For example, victims' social networks can provide a forum for expressing emotions and developing coping strategies. Having a positive social support network can also enhance victims' autonomy and self-confidence overall, increasing their confidence in their ability to enact adaptive strategies. Finally, members of victims' social support networks may challenge their use of maladaptive strategies. This theorized mediated model was evaluated in sample of 106 college women who had experienced sexual assault who completed two surveys, six months apart. Specifically, social support was examined as a predictor of reduction in PTSD symptoms and trauma-related coping was examined as a mediator of this relationship. Among the 90 women who reported PTSD symptomatology at the initial assessment, perceived support from friends and a significant other significantly predicted a decline in symptomatology over six months. Maladaptive coping (avoidant and ruminative strategies) emerged as a significant mediator of this relationship. Specifically, those women who reported greater perceived social support reported less reliance on maladaptive coping. Less reliance on maladaptive coping predicted reductions in PTSD symptomatology.

Coping Self-Efficacy Mediates the Effects of Negative Cognitions on Posttraumatic Distress

Although cognitive distortions have predicted posttraumatic distress after various types of traumatic events, the mechanisms through which cognitive distortions influence posttraumatic distress remain unclear. We hypothesized that coping self-efficacy (i.e., the belief in one's own ability to manage posttraumatic recovery demands) would operate as a mediator between negative cognitions (about self, about the world, and self-blame beliefs) and posttraumatic distress. In the cross-sectional Study 1, data collected among 66 adult female victims of child sexual abuse indicated that coping self-efficacy mediated the effects of negative cognitions about self and about the world on posttraumatic distress. The same pattern of results was found in a longitudinal Study 2, conducted among 70 survivors of motor vehicle

Thursday: 8:00 a.m. – 9:15 a.m.

accidents. Coping self-efficacy measured at 1 month after the trauma mediated the effects of 7-day negative cognitions about self and about the world on 3-month posttraumatic distress. In both studies self-blame was not related to posttraumatic distress and the effect of self-blame on posttraumatic distress was not mediated by coping self-efficacy. The results provide insight into a mechanism through which negative cognitions may affect posttraumatic distress and highlight the potential importance of interventions aimed at enhancing coping self-efficacy beliefs.

The Contribution of Ways of Coping and Sense of Belonging to the College in Times of Ongoing Terror

This study examined the contribution of ways of coping and sense of belonging to the college to the distress reactions of college students in a conflict zone. The sample consisted of 500 Israeli students from a College, which is situated in an area under recurrent attacks by Qassam rockets. Participants completed self-report questionnaires assessing PTSD, additional psychiatric symptoms, daily activities, ways of coping, and sense of belonging to their college. Results revealed that elevated levels of distress, as manifested in PTSD symptoms, additional psychiatric symptoms and disruption in daily activities were associated with level of exposure to Qassam Rockets. In addition, accommodation as a way of coping and sense of belonging to the college contributed to lower stress responses, while using alcohol, disengagement and seeking support contributed to higher distress levels. Moreover, sense of belonging moderated the relations between accommodation as a way of coping and distress measures. Concluding, cognitive and social factors have both unique and interactive effects in coping with continuous threat.

Cross-Sectional and Longitudinal Predictors of Trauma Responsiveness and Symptom Persistence

Findings from two studies will be presented that examined social and cognitive variables predictive of trauma responsiveness and symptom persistence. To examine trauma responsiveness, data from the National Comorbidity Survey-Replication (NCS-R) were used to test several mediational models examining the extent to which social support (family, friends, spouse) and cognitive (i.e., worry) variables mediate the relationship between trauma exposure and PTSD presence. Worry was chosen as the primary cognitive variable as a recent prospective study (Calmes & Roberts, 2007) found that worry was predictive of anxiety. Preliminary analyses indicate that preconditions necessary to test for mediation (Baron & Kenny, 1986) were present for all variables. In addition, three mediational models were tested that examined the extent to which specific dimensions of marital relationships (i.e., disagreements, discord, and shared activities) mediate the relationship between trauma exposure and PTSD presence. To examine symptom persistence, symptoms of PTSD and social support were assessed among 630 burn victims at four time points (one month, six months, 1 year, and 2 years). Preliminary analyses suggest remarkable stability in symptoms across time. The presentation will focus on cross-lagged effects of social support on subsequent PTSD symptoms.

Gathering and Implementing Evidence on Psychological Interventions to Prevent and Treat PTSD

(Abstract #196218)

Symposium/Panel (Clin Res, Prev EI)

Salons 4-6, 3rd Floor

Bisson, Jon, DM, FRCPSYCH¹; Roberts, Neil, PhD²; Kitchiner, Neil, MSC³; Andrew, Martin, MBChB, MRCPSYCH⁴; Lewis, Catrin, BA¹; Kenardy, Justin, PhD⁵

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The results of two Cochrane Systematic Reviews on the efficacy of psychological interventions to prevent and treat PTSD will be presented. This will be followed by a description of how this evidence is being implemented into clinical practice in a Traumatic Stress service.

Multiple Session Early Psychological Intervention to Prevent and Treat PTSD: A Cochrane Review

Over the past 25 years or so clinicians have been increasingly involved in attempts to develop interventions that might mitigate against the effects of trauma and prevent the onset of chronic PTSD. For a number of years single session interventions such as Psychological Debriefing were a widely used and popular form of intervention amongst mental health professionals. Psychological debriefing came under increasing scrutiny in the 1990's and has been the subject of a previous Cochrane Review which found no evidence for the efficacy of single session individual debriefing. Increasingly the field has turned its attention to other models of intervention, including brief forms of CBT, hypnotherapy and counselling. A number of recent studies have been conducted to evaluate some of these forms of intervention.

This presentation will describe the methodology and presents the results of a new Cochrane systematic review of 25 randomized controlled trials of psychological treatments and interventions (excluding single session interventions) aimed at either preventing PTSD or treating acute PTSD.

Cochrane Review of Psychological Treatments for Chronic PTSD

The Cochrane review of psychological treatments for chronic PTSD, first published in 2005 (Bisson and Andrew, 2005) has recently been updated. In the last three years over ten new randomised controlled trials of psychological treatments for PTSD have been published. These have been added to the trials that had already been identified and new meta-analyses performed. The results continue to confirm that trauma focused cognitive behavioural therapy and eye movement desensitisation and reprocessing are effective in the treatment of chronic PTSD and appear to be superior to other psychological treatment approaches. The increased number of studies has also allowed sensitivity analyses to be performed to determine the influence of specific factors, for example quality of the methodology, on outcomes. The methodology used and the results of the systematic review will be presented and their clinical implications discussed.

Bisson, J. & Andrew, M. (2005) Psychological treatment of Posttraumatic stress disorder. Cochrane Database of Systematic Reviews.

Trauma Focused Psychological Therapies in the Cardiff and Vale NHS Traumatic Stress Service

There is a growing demand for evidence based interventions that can prevent or treat PTSD. A shortage of therapists trained to deliver trauma focused psychological therapies (TFPT) within the United Kingdom has led to long waiting lists. In an attempt to increase therapeutic capacity and improve timely access to

60

evidence based interventions, the Cardiff and Vale of Glamorgan Traumatic Stress Service has developed a range of innovative approaches. These have been informed by research including the two systematic reviews presented in this symposium and aim to implement their clinical implications. This presentation will describe a range of clinical initiatives adopted by the service including an education programme for mental health professionals in small groups followed by weekly clinical supervision to enable delivery of trauma focused psychological therapies; rapid access to assessment and treatment for victims of violence referred by a national charity; and a programme to train front line health, emergency services, social services and voluntary staff to deal with distressed people following traumatic events in a sympathetic and empathic manner, acknowledging the importance of practical, pragmatic support and the lack of need for formal psychological interventions for everybody.

Elucidating the Relationship Between Substance Use and PTSD: Perspectives From the Lab to the Clinic

(Abstract #196371)

Symposium/Panel (Asses Dx, Clin Res) **Monroe Ballroom, 6th Floor**

Waldrop, Angela, PhD¹; Brady, Kathleen, PhD¹; Resnick, Heidi, PhD¹; Kaysen, Debra, PhD²; Atkins, David, PhD³; Simpson, Tracy, PhD⁴; Lindgren, Kristen, PhD²; Owens, Gina P., PhD⁵; Chard, Kathleen M., PhD⁶; Lewis, Jennifer, PhD⁷

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Increases in substance abuse, problem drinking, and diagnoses of alcohol use disorders (AUD), have all been associated with trauma exposure. One difficulty with disentangling the relationship between substance use and trauma exposure is that much of the literature conducted to date has been cross-sectional and retrospective. This symposium brings together three studies examining aspects of the relationship between trauma exposure and substance use. The first speaker presents results from a laboratory experiment testing mechanisms for the relationship between risk-taking behavior and PTSD to examine aspects of the relationship between PTSD and cocaine dependence. The next speaker presents interview data from a recently trauma-exposed sample suggesting that problem drinking is associated with reduced improvement in PTSD symptoms over time. The last speaker presents data examining substance abuse history as a possible moderator of treatment outcome. These complementary approaches address various aspects of the PTSD/SUD relationship. The findings have both implications for theories of PTSD and comorbidity. Lastly, our discussant will address the implications of these findings for treatment development and implementation.

PTSD, Drug Abuse, and Risky Behavior in Women

Adults with PTSD are 2 to 4 times more likely than those without PTSD to have a comorbid SUD (Kessler et al. 1995). Sexual trauma and crack cocaine use are both associated with increased HIV risk among women. General risk-taking propensity and maladaptive decision-making may partially account for these relationships. This study used two human laboratory measures of risk-taking behavior to examine these associations among community women with PTSD symptoms (PTSD), cocaine dependence (COC), both (COC/PTSD), or neither. Risk tasks were delay discounting (DD) and the Balloon Analogue Risk Task (BART). COC/PTSD had dramatically lower CAPS scores compared to PTSD, especially hyperarousal symptoms. In the COC/PTSD group, more severe re-experiencing symptoms were associated with more cocaine use on using days. Cocaine use severity and frequency but not PTSD

symptom totals had a positive relationship with DD. This pattern did not hold for BART scores. Group comparisons indicated that 1) PTSD symptoms and cocaine dependence were independently associated with higher BART scores, and 2) the COC group discounted monetary rewards more than did all other groups. The rapid assessment of risk-taking and discounting tendencies may aid in monitoring change in interventions that address maladaptive behaviors such as HIV risk.

Alcohol Problems and the Course of Posttraumatic Stress Disorder in Female Crime Victims

Complex relationships between PTSD and problem drinking have been well-documented. Although some studies have demonstrated PTSD increasing drinking, others suggest alcohol problems may be associated with a more severe course of PTSD. However, little longitudinal research with acute trauma samples has been conducted. The present study examines the impact of alcohol use and consequences on the course of PTSD. Participants were seen 1, 3, and 6 months after exposure to a sexual or physical assault (n = 65). Measures include the Timeline Followback procedure, the Drinc, and the Clinician Administered PTSD Scale. There was a significant interaction between current AUD and days since the assault such that those with alcohol abuse/dependence have a slower recovery from PTSD symptoms. The model suggested participants with current AUD have fewer PTSD symptoms immediately after the trauma, but do not show the typical recovery curve. On average, they changed little over the 6 months. Higher levels of drinking consequences also appeared to predict slower recovery, predominantly at high levels of alcohol consequences. Results highlight the importance of longitudinal methodologies in elucidating the nature of the relationship between PTSD and alcohol misuse. Findings suggest early intervention strategies for women presenting post-trauma with alcohol problems may be indicated.

Relationships Among Substance Abuse History, Anger, and PTSD for Veterans in Residential Treatment

The authors will discuss changes in Veterans cognitions after attending a 7 week residential PTSD program, using Cognitive Processing Therapy. One hundred and eighty-two veterans were screened upon admission to the program and again at discharge. Participants were assessed using the Clinician Administered PTSD Scale and completed self-report measures including the State-Trait Anger Expression Inventory-2 and Beck Depression Inventory. History of substance abuse or dependence was also assessed. Seventy-three percent of respondents were male; two thirds of the sample were Caucasian and one third were African American. Fifty-six percent of participants served in the Vietnam War, 25% post-Vietnam War, 14% Persian Gulf War, 3% Iraq, and 1% Afghanistan. Results of a repeated measures MANOVA indicated significant main effects for drug dependence history, time, and the interaction between time and drug dependence history. Follow-up analyses found significant differences between veterans with and without a drug history for anger expression at pre- and post-treatment. Initial findings suggest that anger expression may be particularly relevant in treatment with individuals with a drug dependence history. Implications for care will be discussed.

Papers

Interpersonal Violence

Salons 7 – 9, 3rd Floor

Chair: Lars Weisaeth, MD, PhD, *Norwegian Centre for Violence and Traumatic Stress Studies, Ullevål University Hospital, Oslo, Norway*

Exposure to Assault Violence

(Abstract #195978)

Paper Presentation (Practice, Asses Dx)

Johansen, Venke A., PhD¹; Weisaeth, Lars, MD, PhD²
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²*Norwegian Centre for Violence and Traumatic Stress Studies, Ullevål University Hospital, Oslo, Norway*

The purpose was to evaluate short- and long-term psychological consequences and the impact on quality of life (QoL) after exposure to physical assault.

A longitudinal design with three repeated measures (n=143 at T1). Questionnaires: IES -22, PD (7 items), Social Provisions Scale, Generalized Self-Efficacy Scale and WHOQOL-Bref. The predictors of PTSD symptoms were analysed in relation to PD, physical injury, perceived life threat, prior experience of violence, perceived social support (PSS), and perceived self-efficacy (PSE). Furthermore the predictive value of PTSD symptoms for QoL was examined.

Findings showed a high prevalence of PTSD symptoms. Perceived life threat was a predictor of PD and early PTSD predicted subsequent PTSD. Low PSE was a predictor of PTSD. Furthermore, lack of PSS was a predictor of PTSD symptoms at T3. The presence of PTSD symptoms predicted lower QoL, both from an acute and prolonged perspective.

Our findings support the understanding of PTSD as a complex phenomenon. Being aware of symptoms such as perceived life threat and PD during the event and PTSD symptoms in the acute phase, would help to identify some of those in need of special follow-ups.

Self-Medication of PTSD by an Amphetamine-Like Substance: Effect on Paranoia in Somali Ex-Combatants

(Abstract #196007)

Paper Presentation (Mil Emer, Asses Dx)

Odenwald, Michael, PhD¹; Hinkel, Harald, PhD²; Elbert, Thomas, PhD³
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³*University of Konstanz, Konstanz, Germany, Germany*

The leaves of the khat shrub (*Catha edulis*) contain the amphetamine-like cathinone and are not restricted by law in Somalia. Binge use and early onset in life are related to the development of psychotic disorders.

Using a cross-sectional design, trained local staff interviewed 8,723 military personnel in Somalia. We used selected items from the Composite International Diagnostic Interview, from the Somali version of the Posttraumatic Stress Diagnostic Scale, and assessed attempts to self-medicate PTSD. Group differences were explored using non-parametric and Chi2 tests.

Respondents with PTSD more frequently indicated that khat helps them to forget war experiences (77.6% vs. 16.0%, p MORE THAN ARROW .001). Khat chewers with PTSD had a higher mean khat intake in the previous week (18.8 'bundles' ± 16.3 vs. 8.7 ± 10.2, p MORE THAN ARROW .001). Respondents who self-medicate PTSD had the highest intake (19.4 ± 16.5) and clearly differed from those

participants with PTSD who did not (7.5 ± 5.2; p < .001). In our regression model, self-medication was the strongest predictor for paranoia (OR = 4.179, CI99% 1.012 – 8.677; Nagelkerke's R .309). Among the 287 khat chewers with PTSD and self-medication the prevalence of paranoia reached 31.4%.

We document self-medication of PTSD in a non-western war-zone. In Somalia, attempts to self-medicate PTSD by using khat cause paranoid symptoms.

Correlates of Symptom Reduction in Treatment Seeking Survivors of Torture

(Abstract #196408)

Paper Presentation (Civil Ref, Clin Res)

Raghavan, Sumithra, BA¹; Rosenfeld, Barry, PhD²; Keller, Allen, MD²; Rasmussen, Andrew, PhD²
¹*Fordham University, Bronx, New York, USA*
²*New York University, New York, New York, USA*

The torture treatment movement is into its second quarter century, and yet empirical examinations of clients' improvement over time remain scarce. The present study examines correlates of symptom reduction in a multinational refugee sample (N = 189) attending a torture treatment center in New York City. Clients were assessed for clinical symptoms using the Brief Symptom Inventory and Harvard Trauma Questionnaire during the intake process and six months following intake. Data revealed statistically significant decreases in clinical symptoms at follow-up. Although there were no demographic correlates of improvement, securing immigration status was predictive of clinical improvement in the full sample. Regression models revealed that individual therapy, psychiatric appointments, and attendance at educational sessions were predictive of improvement beyond the effects of immigration status. A substantial number of clients (n = 80) displayed clinically significant improvement on at least one of the measures, as reflected by a decline in scores by at least one standard deviation. A subsample of clients who endorsed elevated levels of clinical distress at intake (n = 90) also displayed statistically significant improvement, which was moderated by immigration status alone. Interpretation of these findings and implications for torture treatment centers will be discussed.

Addressing Ethical Dilemmas of Trauma Mental Health in Contemporary Wars and Terrorism

(Abstract #196147)

Workshop/Case Presentation (Sos Ethic, Civil Ref) Salon 3, 3rd Floor

Stone, Andrew, MD¹; Weine, Stevan, MD²; Henderson, Schuyler, MD³
¹*VA Medical Center Philadelphia and Univ. of Pennsylvania, Philadelphia, Pennsylvania, USA*
²*University of Illinois at Chicago, Chicago, Illinois, USA*
³*Division of Child and Adolescent Psychiatry, Columbia University, New York, New York, USA*

The trauma paradigm has varying degrees of explanatory power in the current sociopolitical context. The relationship of trauma to political relations, mental health services, and professional obligations is exposed respectively in explanatory models of terrorism focusing on personal traumatization (Speckhard 2006), gaps uncovered by journalists in services for Iraq and Afghanistan veterans implicated in murders since returning home (Sontag and Alvarez 2008), and treatment of veterans subject to possible redeployment (Stone 2008). These cases use trauma models to explain psychopathology at the intersection of war and civilian life. Contemporary wars and terrorism place trauma professionals at this intersection. This position is fraught with ethical dilemmas about the use of trauma explanatory models with political, social, and professional consequences. This workshop will explore these ethical concerns via specific cases. The presenters will apply a

Thursday: 8:00 a.m. – 9:15 a.m.

62

discourse structured on the nature of personal, professional, institutional and humanitarian obligation that has been previously described for mental health leadership (Weine 2006). We claim that through collaborative discourse on the nature of obligations, trauma mental health professionals will be better prepared to address these crucial ethical concerns. Participants will be invited to pose other examples for discussion

Creating a Statewide Trauma-Informed System of Care

(Abstract #196465)

Workshop/Case Presentation (Sos Ethic, Commun) Salon 1, 3rd Floor

Franks, Robert, PhD¹*; *Lang, Jason, PhD²

¹Connecticut Center for Effective Practice, Yale University, Farmington, Connecticut, USA

²Connecticut Center for Effective Practice, Farmington, Connecticut, USA

This workshop will provide a case study of the work underway in the State of Connecticut to develop a trauma-informed system of care in behavioral health, child welfare and juvenile justice. Authors will present recent efforts to identify a range of trauma-informed services, to develop mechanisms for dissemination and quality assurance for evidence-based practices, and to develop agency policies and procedures to guide and provide a context for best practices. Presenters will detail efforts in Connecticut and provide an overview of other similar statewide efforts across the United States. Challenges, barriers and achievements will be highlighted.

Audience members will be engaged to share their own efforts in developing systemic policies and procedures and discuss common goals and activities. Recommendations and opportunities for further collaboration will be explored.

Thursday, November 13

9:30 a.m. – 10:45 a.m.

Keynote

Realpolitik and the Pursuit of International Criminal Justice: A Perennial Conflict?

(Abstract #196670)

Keynote Address Grand Ballroom, 4th Floor

Bassiouni, M. Cherif, JD, LLB, LLD, LLM¹

¹DePaul University College of Law, Chicago, Illinois, USA

It is commonly said that “what is terrorism to some is heroism to others”. Historically, states have benefited from the monopoly of violence to the exclusion of others. More recently, enhanced by globalization, individuals and small groups have effectively challenged states’ monopoly on violence and have been able to use a strategy of low-level violence with considerable socio-psychological and political impact. At the same time, many governments have used fear in order to expand their powers and political durability by enhancing the public perception of vulnerability, in many instances violating or abridging individual civil rights, although these reactionary fear-tactics by governments have usually not proven to be effective.

The international legal regimes applicable to the regulation of collective violence are hopelessly mired in government politics. The law of armed conflict favors states against insurgent groups, even though the latter may have valid legitimacy claims. Conflicts of an internal character are outside the purview of the protection of international humanitarian law and thus favor incumbent governments irrespective of their illegitimacy. Other legitimate claims advanced by non-state actors find themselves without peaceful resolution mechanisms and thus appear to leave them only with the option of resorting to violence.

In reality, we need a genuinely modern international legal order to ensure that terror-violence is prevented and that all victims have access to systems of justice and redress. In this year of the 60th anniversary of the Universal Declaration of Human Rights, while applauding that visionary declaration, we need to review its impact through the last six decades, and apply its spirit to address the many issues involving our planet and its inhabitants today.

Concurrent Session 2

Thursday, November 13

11:00 a.m. – 12:15 p.m.

Recent Developments in PTSD Treatment Outcome Research

(Abstract #195919)

Symposium/Panel (Clin Res, Practice) Wabash Room, 3rd Floor

Resick, Patricia, PhD¹; Rothbaum, Barbara, PhD²; Foa, Edna, PhD³; Bryant, Richard, PhD⁴

¹Women’s Health Sciences Division, National Center for PTSD/Boston VA Healthcare System, Boston, Massachusetts, USA

²Department of Psychiatry, Emory University, Atlanta, Georgia, USA

³Department of Psychiatry, University of Pennsylvania, Philadelphia, Pennsylvania, USA

⁴School of Psychology, University of New South Wales, Sydney, New South Wales, Australia

Although cognitive behavior therapy is the treatment of choice for PTSD, there is a need to develop more effective treatments and to determine factors that influence treatment response. This symposium presents four studies that address treatment outcome research. The initial paper provides an overview of treatment predictors from two trials of cognitive processing therapy. The second paper reviews the differential responses to treatment of survivors of terrorist attacks and motor vehicle accidents. The third paper reviews predictors of outcome following EMDR and Prolonged Exposure. The fourth paper overviews a series of studies that have used structural and functional fMRI to identify the neural factors that predict response to CBT and also the impact of CBT on neural functioning.

Pretreatment Predictors of Treatment Response Across Two Studies of Cognitive Behavioral Treatment for PTSD

Patricia A. Resick, Jaimie Gradus, and Shireen Rizvi

This presentation examines predictors of treatment outcome from two studies of female participants with PTSD using hierarchical linear modeling (HLM). Study 1 compared CPT and PE (n= 145); study 2 compared cognitive therapy (CPT-C) and written accounts (WA) (n= 97). Study 1 found being younger or having lower IQ predicted dropout from treatment. Higher depression and guilt at pretreatment were associated with greater treatment response. Increased anger predicted dropout of PE, while older women in PE and younger women in CPT had the best outcomes. In Study 2, among those receiving CPT-C age was associated with less improvement. More dysfunctional cognitions (PBRs) were associated with more improvement. In contrast, for WA participants, PBRs and age did not predict changes in PTSD over time. Unlike CPT-C, anger and depression predicted treatment response among WA participants. These findings suggest that there might be different predictors of response to cognitive therapy versus exposure therapy.

Efficacy of the Developmentally Adjusted Prolonged Exposure Protocol With Posttraumatic Youth: Comparing Victims of Terrorist Attacks With Victims of MVA

Foa, E.B, Gilboa-Schechtman, E., Shafran, N., Harish-Avidan, S.Daie, A., Rachamim, L. and Apter, A.

This study examined (a) clinical presentation of posttraumatic distress in pediatric victims of terrorist attack (TA) and motor vehicle accident (MVA) survivors; (b) efficacy of a developmentally adjusted prolonged exposure (PE) treatment in an open trial in TA vs. MVA; and (c) the efficacy of PE vs. time-limited psychodynamic therapy (TLDT) among adolescents in a randomized control trial (RCT). The TA and MVA victims were mostly similar on distress measures. The open trial indicated effect sizes of PE (intent-to-treat) were 1.78, 1.51 and 1.3 for PTSD, depressive and general anxiety symptoms, respectively. The RCT indicated that the effect sizes for PE and TLDT were 1.53, 1.45 and 2.7 and 1.07, 1.28 and

Thursday: 11:00 a.m. – 12:15 p.m.

64

1.48 for PTSD, depressive and general anxiety symptoms, respectively. PE resulted in greater loss of PTSD diagnosis compared to the TLDT (88% and 50%). Based on independent clinical evaluation of global functioning, the effect size of PE and TLDT were 4.74 and 1.42, respectively.

Predictors of Treatment Response for EMDR and Prolonged Exposure

Barbara Rothbaum

Predictors for response to treatment in a controlled study aimed to evaluate the relative efficacy of Prolonged Exposure (PE) and Eye Movement Desensitization and Reprocessing (EMDR) compared to a no-treatment wait-list control (WAIT) in the treatment of PTSD in adult female rape victims were examined. In this study, 74 participants with PTSD were randomly assigned to one of the three experimental conditions to achieve 20 completers per group. Independent Assessors blind to the treatment condition administered standard measures of PTSD and related symptoms. Improvement in PTSD, depression, dissociation, and state anxiety was significantly greater in both PE and EMDR group than the WAIT group. PE and EMDR did not differ significantly for change from baseline to either post-treatment or 6-month follow up measurement for any quantitative scale. EMDR subjects with 2 or more comorbid diagnoses, however, improved significantly less than all other active treatment subjects. At post-treatment and 6-months, 95% and 94% of PE subjects and 75% and 74% EMDR subjects no longer met *DSM-IV* PTSD criteria, respectively. At the 6-month follow-up assessment, 78% of those who received PE and 35% of those who received EMDR met criteria for good end state functioning ($p=.017$).

Neural Predictors of CBT Response

Richard A. Bryant

Animal and human studies have indicated that the medial prefrontal cortex and amygdala are implicated extinction learning. CBT is a form of extinction learning and may involve the same neural networks. This study recruited patients with PTSD ($N = 14$) and assessed them using structural and functional MRI as they viewed fearful faces. Patients were then treated with 8 sessions of CBT and assessed 6 months later. In terms of structural MRI, good response to CBT was significantly predicted by volume of rostral anterior cingulate cortex. In terms of functional MRI, poor response to CBT was predicted by greater activation of the bilateral amygdala during subliminal presentation of fearful faces. Patients' reductions of PTSD symptoms over treatment resulted in greater recruitment of anterior cingulate cortex during fear processing after treatment. These results are discussed in terms of extinction models of exposure therapy and point to possible means to enhance treatment response.

Complex Trauma in Children and Adolescents: Conceptualization and Assessment

(Abstract #196052)

Symposium/Panel (Child, Asses Dx)

State Ballroom, 4th Floor

Nader, Kathleen, DSW¹; Fletcher, Kenneth, PhD²; Ford, Julian, PhD³; Briere, John, PhD⁴; Pelcovitz, David, PhD⁵; van der Kolk, Bessel, MD⁶; DeRosa, Ruth, PhD

¹Director, *Two Suns, for the Assistance of Traumatized Children and Adolescents*, Cedar Park, Texas, USA

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⁵Department of Psychology and Education, *Yeshiva University*, New York, New York, USA

⁶Department of Psychiatry, *Boston University School of Medicine*, Brookline, Massachusetts, USA

⁷Co-Director, *Cognitive Behavioral Associates*, Great Neck, New York, USA

Researchers/clinicians will discuss important questions regarding the clinical and diagnostic conceptualization of complex trauma in children (AKA Developmental Trauma Disorder). Panel members will discuss the pros and cons of a separate diagnosis vs. PTSD + comorbidities, attachment security issues, age of onset, findings for maltreated youth, and taskforce data findings.

Is a Complex PTSD Diagnosis Needed and Justified?

Ford, J.

Conceptualizations of complex trauma have focused on traumatic stressors that compromise the formation or maintenance of secure attachment bonds with primary caregivers (Brown, in press; Siegel, 2001) and/or biopsychosocial development ("developmentally adverse interpersonal Trauma," Ford, 2005). These formulations and associated models of complex PTSD in childhood (e.g., "Developmental Trauma Disorder," van der Kolk, 2005) raise a critical clinical and research question: "Is a Childhood Complex PTSD Diagnosis needed and justified?" This clinical/nosological and research question is central to the consideration of revisions to the diagnosis of PTSD for children. The formalization of a new childhood complex PTSD diagnosis will be discussed by considering the evidence from clinical case studies involving complicated trauma histories and psychiatric/behavioral comorbidities. Evidence suggests that there are discernable trajectories of attachment security versus insecurity and normative versus Posttraumatic psychobiological adaptations (Ford, in press) that have clinical utility (First et al., 2004) as precursors to the acquisition of self-regulation versus dysregulation of emotion, bodily functioning, cognitive information processing, and relationships in infancy, childhood, and adolescence.

Do We Need a Child Complex Trauma Diagnosis, or, Instead, a Way to Diagnose Ongoing Attachment Symptoms Beyond Age 5?

Briere, J. & Hodges, M.

Although it is clear that children and adolescents may present with a variety of symptoms sometimes informally referred to as complex PTSD or developmental trauma disorder (DTD), such clinical presentations may primarily reflect the effects of early disturbed attachment as it is shaped by biological, sociocultural, and trauma-specific phenomena in subsequent development. It is suggested that the critical symptoms associated with proposed complex trauma diagnoses are those related to problems in self-awareness, affect regulation, and relatedness, all of which may reflect disturbed attachment as it presents in older childhood and adolescence. However, the *DSM* has no way of diagnosing severe attachment disturbance after age 5, implying that such dysregulation terminates at that point. Instead, young children may be given the (relatively undifferentiated) diagnosis of reactive attachment disorder, and then later receive attachment-unrelated diagnoses as they age into older childhood, typically concluding with cluster "A" or "B" personality disorder diagnoses in late adolescence. Although DTD acknowledges attachment disturbance as an important etiology, perhaps what is needed are *DSM* diagnoses that specifically index ongoing and chronic severe attachment disturbance as it presents in older children and adolescents. The relevant literature will be reviewed.

Can Complex PTSD be an Adolescent Onset Problem?

Pelcovitz, D.

Difficulties with affect regulation and relationships with caregivers and peers, use of denial and dissociation as coping mechanisms, alterations in self-concept, somatic complaints and struggles with identity and finding meaning in their lives are well documented in a variety of clinical and research reports on adolescent trauma victims. An important question in discussing the need for a new complex PTSD diagnosis for children is whether the constellation of symptoms described should be limited to children who experienced traumatic events early in their histories or whether there is a subset of adolescents who experience abuse or other types of trauma who develop this constellation of symptoms in spite of relatively healthy preadolescent experiences. Utilizing a

combination of case vignettes and research data on physically abused adolescents and treatment of complex PTSD in this population, the question of whether a new complex PTSD for children should be broadened to include adolescent onset trauma.

A Study of Developmental Trauma Disorder by the NCTSN DSM-V Taskforce

van der Kolk, B., Spinazzola, J., Stolbach, B., Dekell, R., Kisiel, C. & Pynoos, R.

Purpose: Each year over 3,000,000 children are reported to the authorities for abuse and/or neglect in the US. Research has well documented that adverse childhood experiences have a powerful relation to adult health a half-century later and expressed as increased depression, suicide attempts, alcoholism, drug abuse, sexual promiscuity, domestic violence, obesity, and a variety of physical illnesses. Childhood trauma is probably our nation's single most important public health challenge.

Method: Isolated traumatic incidents tend to produce discrete conditioned behavioral and biological responses to reminders of the trauma, as captured in the PTSD diagnosis. In contrast, chronic maltreatment has pervasive effects on the development of mind and brain. This presentation will include data on developmental trauma from four different databases comprising over 80,000 children.

Conclusion: We will present the provisional diagnostic criteria for Developmental Trauma Disorder by the NCTSN DSM V Taskforce.

The Nature and Extent of Traumatic Stress in Refugees

(Abstract #196203)

Symposium/Panel (Asses Dx, Civil Ref) **Crystal Room, 3rd Floor**

Bryant, Richard, PhD²; Hinton, Devon, MD¹; Rasmussen, Andrew, PhD²; Nickerson, Angela, BSC³; de Jong, Joop, PhD⁴

¹Department of Psychiatry, Harvard University, Cambridge, Massachusetts, USA

²School of Medicine, New York University, New York, New York, USA

³School of Psychology, University of New South Wales, Sydney, New South Wales, Australia

⁴Department of Psychiatry, Vrije Universiteit Amsterdam, Boston University School of Medicine, Amsterdam, Amsterdam, Netherlands

This symposium addresses the issue of traumatic stress in refugee populations. There are currently over 20 million refugees in the world today, and significant proportions suffer posttraumatic stress conditions. These papers provide data concerning the extent to which western conceptualizations adequately explain the distress experienced by refugee populations across different cultures. The first two papers focus on the extent to which local idioms capture the extent of the problems experienced by different cultures, and how these local conceptualizations map onto western constructs, such as PTSD. Subsequent papers focus on the nature and extent of traumatic stress and depression on refugee populations, and highlight the role of ongoing threat and anticipatory anxiety on the clinical presentation of populations who have been displaced under conditions of threat.

Key Idioms of Psychological Distress Among Cambodian Refugees
Devon Hinton

Though PTSD can be diagnosed in non-Western populations, the question remains as to whether local idioms of distress play a major role in the local shaping, experiencing, and understanding of trauma-related disorder. The current study examines two key idioms of distress in Cambodian context, "wind attacks" (kaeut khyol), the common local way of describing anxiety symptoms in terms of the local ethnophysiology, and "thinking a lot" (kut caraeun), a local idiom indicating that the mind is overactive, thinking of various topics from current life concerns to past events. Based on a large sample of Cambodian refugees attending a psychiatric clinic in the United States, we examine the ability of these idioms of distress to predict PTSD and PTSD severity (using

the PCL). The results suggest that these cultural syndromes should be specifically evaluated and addressed for treatment to be empathic and effective.

Idioms of Psychological Distress Among Darfuri Refugees
Andrew Rasmussen

The presumption that Western measures of distress are valid for African refugees ignores a rich tradition of indigenous healthcare that includes what Western practitioners would call psychological distress (Patel, 1995), as well as international calls to tailor assessment methods to local populations in disaster settings. We used a rapid ethnographic assessment with focus groups for free listing and traditional healers as key informants to create assessment tools for Darfuris living in eastern Chad. Most problems reported by Darfuri refugees fell into two distress constructs: hozzun (literally "sadness"), and majnun ("madness"). These disorders were both based in trauma and loss, with majnun being a more severe reaction than hozzun. Overlap between PTSD and hozzun was comprised of what Western psychologists would recognize as traumatic intrusion, whereas overlap between PTSD and majnun was comprised of emotional numbing. Most of the remaining indicators of hozzun overlapped with major depression, whereas remaining majnun symptoms were more psychotic in nature, accompanied by a few of the more severe depression symptoms. We report on the differential ability of hozzun, majnun, PTSD (using the PCL-C) and depression (using the BSI Depression subscale) to predict functional impairment using a representative sample of 848 refugees drawn from two camps.

Mental Health and Postmigration Adjustment in the Mandaean Refugees in Sydney, Australia: A Longitudinal Study.
Angela Nickerson and Richard A. Bryant

The Mandaean are a cultural and religious group predominantly from Iraq and Iran who have been subject to centuries of persecution. A longitudinal survey was conducted examining the psychological functioning of the Mandaean refugee community in Sydney at two time-points. Participants in this study included 241 Mandaean who took part in the first survey in 2003, and 315 who took part in the second survey in 2006-2007. The community's psychiatric status was assessed including posttraumatic stress disorder, depression, grief, anger and mental health-related disability. Pre-migration trauma, postmigration living difficulties and the effect of government policies including immigration detention and temporary protection on Mandaean mental health were also examined. At the time of the first survey, the community exhibited high levels of psychopathology and functional disability. Overall, the community's psychological status had improved by the second assessment. This may be related to the large-scale change in visa status that occurred in the community between the two surveys. The relative importance of various factors in predicting long-term mental health in the Mandaean will be discussed. In addition, the effect of ongoing threat on the psychological functioning of this community will be explored.

Effectiveness and Cost-Effectiveness: Effectiveness of Western Style Treatments in Non-Western Community Settings

Joop de Jong, Ivan Komproe, Herman Ndayisaba, Sotheara Chhim

We did a naturalistic multi-site cost effectiveness study to assess the effectiveness of the implementation of psychosocial programs on mental health, psychosocial and rehabilitation in five low-income countries affected by violence (Burundi, Gaza, Cambodia, Nepal and Uganda). In a naturalistic design, participants received either individual care with psychotropics, individual care without psychotropics, or supportive group therapy. Treatment conditions were compared with a control group in areas where mental health services are not available. The participants were interviewed before treatment (T1) and at 5 months post treatment (T2). The effects of the interventions were evaluated in terms of a) psychological distress, b) psychiatric symptomatology, c) disability and d) limitations due to emotional problems, social functioning, physical functioning. Results will be presented in terms of effect sizes and

costs and benefits of interventions for Burundian patients (n = 236) and controls (n=249) as well as Cambodian patients (n=279) and controls (n=231).

Psychological Outcome of Motor Vehicle Accidents

(Abstract #196216)

Symposium/Panel (Clin Res, Asses Dx) **Monroe Ballroom, 6th Floor**

Kim, Yoshiharu, MD¹; Matsuoka, Yutaka, MD¹; Schnyder, Ulrich, MD²; Freedman, Sara, PhD³; Ursano, Robert, MD⁴

¹National Institute of Mental Health, Kodaira, Tokyo, Japan

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⁴Uniformed Services University, Kensington, Maryland, USA

Motor vehicle accident (MVA) is a common trauma, deteriorating the quality of life and causing chronic mental disorders such as PTSD. As the mortality cases have been decreasing in many countries, the number of rescued and wounded victims has been increasing, so as to enlarge the population with high risk for PTSD and other psychosocial problems. MVA also provides a unanimous cohort for preventive intervention for PTSD, in that it is accompanies little diversity in the nature of trauma. Cultural factors may influence the outcome, but as yet there is no comparable data on the mental health of of MVA victims cross-culturally. We here present the results of three longitudinal studies conducted in different countries, namely, Japan, Switzerland and Israel. The data from Israel study will show the efficacy of multi-modality of early intervention, which is also very suggestive for the treatment of victims of other types of trauma.

Psychiatric Morbidity Following a Motor Vehicle Accident and Its Impact on Health-Related Quality of Life

Yutaka Matsuoka, Daisuke Nishi, Satomi Nakajima, Yoshiharu Kim

Purpose: By assessing the incidence of psychiatric illness after involvement in a motor vehicle accident (MVA) in Japan, we studies the predictors of psychiatric illness, and the association between psychiatric illness and health-related quality of life (HRQOL).

Method: 100 injured patients were interviewed immediately at an emergency department and 1-month after involvement in a MVA. Main outcome measures were the Mini-International Neuropsychiatric Interview, CAPS, and the Medical Outcomes Study Short Form-36 Health Survey (SF-36).

Results: Thirty-one patients showed some form of psychiatric illness at 1-month follow-up. The majority of illnesses consisted of depression (major depression, n = 16; minor depression, n = 7) and PTSD (full PTSD, n = 8; partial PTSD, n = 16). Psychiatric morbidity was predicted by a sense of life threat (odds ratio [OR] = 4.2), elevated heart rate (HR) (OR = 1.6), and higher IES-R intrusion subscale score (OR = 1.1). Patients with psychiatric illnesses had lower SF-36 scores than those without psychiatric illness.

Conclusion: This study showed that psychopathology following a MVA in Japan is common and is associated with poor HRQOL. A combination of a sense of life threat, HR and IES-R intrusion allowed for significant prediction of psychiatric morbidity.

Quality of Life Following Accidental Injury

Ulrich Schnyder, Lutz Wittmann, Hanspeter Moergeli, Stefan Buchi

Purpose: Using latent growth curve modelling, we studied the change of quality of life (QOL) over one year in severely injured accident survivors, and investigated the interaction of loss of QOL with psychopathological and social variables.

Methods: 323 recent accident survivors who were hospitalized for at least two consecutive nights were assessed within five days of the trauma, six and twelve months post-accident. Measures included the PDEQ, CAPS, HADS, and PRIME-MD. to assess QOL, we used Henrich and Herschbach's Questions on Life Satisfaction FLZ.

Findings: QOL decline (mean values: T1=76.8, T2=65.2, T3=60.3)

was best described by a linear model. Both intercept and slope differed significantly from zero. Whereas the intercept showed significant variance, the slope did not. Presentation of findings will focus on the interaction of the decrease in QOL with posttraumatic pathology and social variables.

Conclusions: In a great majority of survivors, QOL declines steadily over one year following accidental injury. This decline is not isolated but interacts with further psychopathological and social developments. Implications for therapeutic interventions are discussed.

Preventing PTSD by Early Treatment in Road Traffic Accidents and Other Events

Sara Freedman, Arie Y. Shalev, Rhonda Addesky, Yael Errera, Yossi Israeli-Shalev, Tamar Peleg

Background: Chronic PTSD is disabling and treatment resistant. We evaluated the ability of cognitive therapy (CT), prolonged exposure (PE), an SSRI and delayed PE to prevent PTSD in survivors of road traffic accidents (80%) and other events.

Methods: Adult survivors of traumatic events with Acute PTSD were randomized (equipose-stratified randomization) to 12 sessions / 12 weeks of CT (n=51) or PE (n=73), or to blindly receive either escitalopram (20mg) or placebo (n=52), or to remain on a waitlist (WL) and receive PE three months later. Qualified clinicians, blind to treatment allocation, administered the Clinician Administered PTSD Scale (CAPS) before and after treatment.

Results: CT and PE similarly reduced the prevalence of PTSD at five months (18.2% and 21.4%) whereas the escitalopram, placebo and WL conditions yielded 61.9%, 58.8% and 57.4% PTSD (p<0.001). Early and Late PE similarly reduced the prevalence of PTSD at eight months (21% and 19%). Survivors with partial PTSD recovered equally well with or without treatment.

Comment: In this presentation we will compare the results of road traffic accidents victims with those of other traumatic events.

The Relationship Between Killing, Mental Health, and Functional Impairment in Veterans and Police

(Abstract #196376)

Symposium/Panel (Mil Emer, Sos Ethic) **Adams Ballroom, 6th Floor**

Maguen, Shira, PhD¹; McCaslin, Shannon, PhD¹; Insicht, Sabra, PhD²; Metzler, Thomas, MA²; Marmar, Charles, MD²; Litz, Brett, PhD³; Seal, Karen, MD²; Lucenco, Barbara, PhD⁴; Gahm, Gregory, PhD⁵; Reger, Mark, PhD⁵

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⁴Washington State Dept. of Social and Health Svcs, Olympia, Washington, USA

⁵Madigan Army Medical Center, Tacoma, Washington, USA

This symposium will examine the impact of killing among Vietnam veterans, police officers, and Operation Iraqi Freedom (OIF) soldiers. The relationship between duty-related killing, mental health symptoms, and functional impairment will be examined. These findings will be presented within a larger theoretical framework.

The Impact of Killing in Vietnam Veterans

The purpose of this study is to examine the impact of killing among Vietnam veterans serving in a war zone. Utilizing the NVVRS clinical dataset, we examined the impact of killing after controlling for exposure to traditional combat. When examining PTSD as the outcome variable, we found killing accounted for an additional 13% of the variance in PTSD symptoms above and beyond traditional combat, with the combined variables explaining 29% of the variance in PTSD symptoms. Furthermore, the standardized beta weight for killing was about three and a half

times greater than that of traditional combat. We also examined dissociation as an outcome variable and found that after killing was added to the model, traditional combat no longer significantly predicted dissociation, yet killing was strongly related to dissociation. Killing was also significantly associated with alcohol, marijuana, and polysubstance abuse. When examining functional impairment outcomes, killing was associated with greater marital problems, family adjustment, occupational difficulties, and violent behaviors. We present findings related to different types of killing within the war zone and contextualize killing within a larger theoretical framework. Overall, killing is associated with a number of mental health symptoms and functional impairment, even after controlling for traditional combat exposure.

Impact of Line of Duty Killing/Serious Injury in Urban Police Officers

The purpose of this study is to examine the impact of killing or seriously injuring another person in the line of duty among 735 urban police officers. The officers were cross-sectionally surveyed on trauma exposure and mental health symptoms. We conducted a series of hierarchical linear regressions to ascertain the impact of killing/seriously injuring another person over and above other critical incident exposure on PTSD symptoms and depression. Years of service, gender, and personal trauma history were associated with killing/seriously injuring someone and were included in the analysis. 25% of the officers endorsed having to kill or seriously injure someone in the line of duty. This item significantly predicted PTSD and depression symptoms over and above other cumulative critical incident exposure. Impact of killing and causing serious injury was also examined for each PTSD symptom cluster. This item also significantly predicted all three PTSD symptom clusters, over and above other critical incident exposure. This was most dramatic for avoidance symptoms; the standardized beta weight for killing/injury was nearly six times that of other critical incident exposure. Line of duty killing and causing serious injury is an important predictor of mental health symptoms, emphasizing the importance of addressing this in training and subsequent to critical incidents.

The Impact of Taking Another Life in Operation Iraqi Freedom (OIF) Soldiers Returning From Deployment

The purpose of this study is to examine the mental health impact of taking another life among over 3,000 soldiers returning from Operation Iraqi Freedom (OIF). These data were collected as part of a larger study examining mental health outcomes among soldiers returning from deployments to the Middle East. In this study, we controlled for soldiers witnessing killing, and examined the unique contribution of taking another life in combat. Overall, 40% of the sample reported taking another life during their deployment. Even after controlling for witnessing killing, taking another life was a significant predictor of PTSD symptoms, depression symptoms, and alcohol use. Additionally, taking another life in the war zone significantly predicted anger and relationship problems, even after controlling for seeing killing in the Middle East. Similar to findings with police officers and other veterans of war, soldiers currently returning from modern deployments are at risk of mental health symptoms and related functional impairment due to exposure to killing at war. Consequently, mental health treatment of these veterans should include addressing the impact of taking another life in order to optimize readjustment to civilian life following deployment.

Applying Innovative Technologies in Trauma Research and Clinical Practice

(Abstract #196567)

Symposium/Panel (Res Meth, Bio Med) Salons 7-9, 3rd Floor

Carlson, Eve, PhD¹; Woodward, Steven, PhD²; Dalenberg, Constance, PhD³; Field, Nigel, PhD⁴; Ruzek, Josef, PhD²; Spain, David, MD⁵

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Close monitoring of clinical variables can improve clinical research and practice. This symposium will present examples of innovative uses of technology in trauma research and clinical work. The methods allow researchers and clinicians to collect or monitor detailed data in domains of psychological phenomena, sleep, respiration, and heart rate.

Using a Portable, Automated, Electronic Method to Collect Real-Time Data From Trauma Survivors

Ecological Proximal Assessment (EPA) is a portable, automated, electronic, data collection method that allows recording of clinically-relevant symptoms, moods, cognitions, experiences, and behaviors during daily life. The EPA method provides more accurate and detailed monitoring and data collection in trauma survivors because it does not require distressed people to track, summarize, and recall psychological phenomena. Data will be presented showing some of the unique types of research questions that researchers can use EPA to address, such as what the chronological relationship is between negative posttraumatic cognitions and symptoms; whether there are differences in patterns of emotional dynamics among those who develop PTSD; whether items assessing PTSD symptom criteria measure the constructs they are intended to measure; and whether there are aspects of early responses to trauma that can predict chronicity of symptoms. Examples will also be provided of how EPA might be useful to clinicians and their clients to track problematic symptoms or behaviors. Information will be provided on how to obtain free specialized PDA software to measure psychological phenomena in research participants or clients and a free manual for the EPA methodology.

Using Mattress Actigraphy to Investigate Aspects of Sleep in PTSD

Laboratory studies of PTSD-related sleep disturbance may have limited validity as evidenced by the low rates of nightmares in that context. Consequently, some researchers in this area have turned to ambulatory monitoring methods such as in-home polysomnography and actigraphy. This presentation will describe mat-tress actigraphy, a zero-burden method that transduces large and small sleeper movements, including respiration and the kinetocardiogram. This allows extended unobtrusive measurements of sleep scheduling, continuity/depth, and accompanying autonomic activation. The data to be presented were obtained from a community-residing sample of participants meeting criteria for PTSD, Panic Disorder, or comorbid PTSD+PD, and from controls. Participants were screened for medical sleep disorders in the laboratory, and thereafter studied at home for an average of 15 nights. PTSD participants were distinguished by extended sleep periods (+ ~50 minutes). PTSD and PTSD+PD participants were characterized by increased rates of muscle twitches during sleep as compared to both PD participants and controls, as well as elevated heart rates (+ ~5 BPM) and reduced respiratory sinus arrhythmia magnitudes (~ -25%). Extended in-home mattress actigraphy suggests that PTSD is paradoxically associated with both pro-elongation of sleep and elevated activation/arousal during sleep.

Thursday: 11:00 a.m. – 12:15 p.m.

68

Using Breathing Biofeedback to Enhance Cognitive Behavioral Treatment of Trauma Survivors

Many cognitive-behavioral treatments include breathing retraining or relaxation, but a subset of patients drop out of therapy because they cannot tolerate physiological reactivity. For some, this occurs because they are unable to adequately monitor their physiological symptoms. General guided relaxation protocols in recent years have been augmented by use of inexpensive but accurate biofeedback tools, available for office or client home use. After a brief introduction to heart rate variability analysis, methods of monitoring of heart rate variability will be explained as a more potent form of breathing retraining and affective regulation. Three research projects using biofeedback (a) alone, (b) as a supplement to cognitive therapy with children, and (c) as a supplement to cognitive therapy with adults will be presented.

Interventions Following Terrorism From 3 Months to 5 Years Post-Event

(Abstract #196599)

Symposium/Panel (Disaster, Clin Res) Grand Ballroom, 4th Floor

Cloitre, Marylene, PhD¹; Malta, Loretta, PhD²; Levitt, Jill T., PhD³; Nacasch, Nitsa, PhD⁴; Foa, Edna B., PhD⁵; Huppert, Jonathan D., PhD⁶; Zohar, Joseph, MD⁷; Fostick, Leah, PhD⁸; Tzur, Dana, MA⁹; Clark, David M., DPH¹⁰; Gillespie, Kate, MD¹⁰; Duffy, Michael, PhD¹¹; Bolton, David, PhD¹⁰; Duffy, Michael, PhD¹¹; Gillespie, Kate, PhD¹⁰; Clark, David M., PhD¹²; Foa, Edna B., PhD¹³

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This symposium will present the results of psychosocial interventions following terrorism from 3 months to 5 years post-event. Type as well as the therapeutic focus of interventions for terrorist-related psychological sequelae, particularly as related to the timing of the intervention post-event, will be discussed.

Community Based Cognitive Therapy for PTSD Following the Omagh and London Bombs in the UK

Controlled trials have shown that trauma focused cognitive behaviour therapies are effective in treating PTSD following non-terrorism related traumatic events. Less is known about the effectiveness of these treatments with terrorism related PTSD. Two studies that focus on this issue are reported. In the first, 91 individuals who developed PTSD following a car bomb in Omagh, Northern Ireland were offered cognitive therapy (CT) based on the Ehlers & Clark (2000) model at an average of 10 months after the event. Assertive outreach was used to identify potential patients. There were no major exclusion criteria. Therapists were national health service staff with modest prior experience with PTSD who received a brief training in CT for PTSD after the bombing. Substantial and significant improvements in PTSD were observed, with pre to post treatment effect sizes (approx 2.2) in line with those reported for CT in trials with non-terrorism related PTSD. The second study is a screen and treat programme that was partly influenced by the Omagh experience and was deployed in London shortly after the July 2005 terrorist bombs. Similar outcomes were

observed with 82 patients treated within 18 months of the bombings. Discussion focuses on the lessons learned from both studies.

Treatment of PTSD Linked to Terrorism and Other Civil Conflict in Northern Ireland: A Randomized Controlled Trial

For four decades the community of Northern Ireland experienced a high level of terrorist violence and other civil conflict. Following the apparent success of cognitive therapy (CT) in treating PTSD following the 1998 Omagh car bomb, the Northern Ireland Centre for Trauma and Transformation (NICTT) was established to make the treatment available to victims of other terrorist and conflict related violence over the preceding decades. In the first phase of the NICTT's work, 58 consecutive referrals with PTSD were randomized to either immediate CT or Wait followed by CT. Patients typically had chronic PTSD (median 5.2 years, range 3 months to 32 years) mostly resulting from multiple traumas. Half had failed previous psychological treatments for PTSD. CT was based on the Ehlers and Clark (2000) model and comprised a median of 8 sessions with clinicians allowed flexibility to vary the number of sessions depending on patient need and co-morbidity. There were no improvements during the wait period. In contrast, immediate CT was associated with significant improvement in PTSD, depression and social/work related disability, which was maintained at follow-up. Discussion focuses on the adaptations of CT that were required for a chronic, multiply traumatized population in the context of ongoing threat.

Prolonged Exposure Therapy (PE) Among Patients Suffering From PTSD Due to Terror Attacks in Israel—An Open Study

Frequency and severity of terror attacks in Israel increased substantially during the second Intifadah, starting in September 2000. As a result, a large population of citizens was exposed directly and indirectly to traumatic events. The psychological consequences of such events can be severe, including posttraumatic stress disorder (PTSD). Prolonged Exposure (PE) therapy has been found effective in various types of traumas, with its beneficial results replicated and disseminated into clinical settings. A recent report of the Institute of Medicine (2007) has suggested that the only treatment for PTSD that gained sufficient evidence for its efficacy is exposure therapy. However, evidence for the efficacy of PE for terror victims is scant. In this lecture I will present a study conducted at Sheba Medical Center in Israel examining the efficacy of PE in terror-related PTSD patients; these patients were referred to the psychiatric clinic due to exposure to terrorist attacks such as suicide bombings, explosive devices, or shooting attacks. Patients undergoing PE therapy were evaluated pre and post treatment for their PTSD and depression symptoms, by PhD level independent evaluators. Preliminary results suggest that PE is extremely effective in the treatment of terror-related PTSD. Data on the full sample will be presented.

Resolving PTSD and Rebuilding Psychological and Social Resources for 9/11-Exposed Individuals

A salient consequence of mass violence is the breakdown of social networks and the satisfaction of basic needs, emotional support and sense of 'felt membership' that they provide. In addition, survivors tend to have reduced expectations of support and to be unprepared for the task of rebuilding their networks. We present the results of an open trial (n=59) in which an established multi-component PTSD treatment was adapted to include (1) the rehabilitation of healthy coping and support seeking perceptions and strategies using Skills Training in Affective and Interpersonal Regulation (STAIR) and (2) a modified version of prolonged exposure (PE) to resolve PTSD. The treatment was implemented by therapists who ranged from very to minimally experienced in CBTs. In addition, number of sessions and of session topics were flexible and collaboratively determined by client and therapist. Results indicated reduction in PTSD symptoms equal to that of a benchmarked RCT (ES = 1.79) as well as substantial improvement in day-to-day functioning (.64), hostility (.82), use of alcohol and drugs to cope (.59) negative mood regulation (.70) and use of social support to cope (.43). Given that social support facilitates

recovery from PTSD and protects against its development, intervention and prevention programs incorporating social support interventions should be considered.

Papers

Recent Developments in PTSD Research

Salon 2, 3rd Floor

Chair: Beth Fischer, PhD,
Harlow Center for Biological Psychology, University of Wisconsin, Madison, Wisconsin, USA

A Prospective Examination of Posttraumatic Stress Symptoms From Motor Vehicle Accident to Recovery

(Abstract #196036)

Paper Presentation (Res Meth, Asses Dx)

Fischer, Beth, PhD¹; Irish, Leah, MA²; Kobayashi, Ichori, MA²; Spoonster, Eileen, RN³; Fallon, William, MD³; Delahanty, Doug, PhD²

¹*University of Wisconsin, Madison, Wisconsin, USA*

²*Kent State University, Kent, Ohio, USA*

³*Summa Health System, Akron, Ohio, USA*

The current PTSD literature is mixed regarding the interrelationship between PTSS, order of symptom presentation, and symptom change over time. The present study examined PTSS, assessed in-hospital, and 6 weeks, 3-, 6-, and 12-months post-mva (n=365). Hierarchical linear modeling was used to systematically track the relationships between PTSS over time. Preliminary analyses suggested that PTSS were highest in frequency and intensity immediately post-mva and gradually decreased over the course of recovery with hyperarousal symptoms demonstrating the slowest rate of improvement over time. Additionally, while hyperarousal was found to be the most prominent predictor of change in intrusion and avoidance over time, change in hyperarousal was also influenced by intrusion and avoidance symptom suggesting a reciprocal relationship. These findings emphasize the significant role of hyperarousal in symptom change and recovery over time, contribute new insight into PTSS theory, and provide insight into pharmacological and clinical treatments that might ameliorate PTSD symptomatology.

Correlates of Acute and Chronic Posttraumatic Stress Disorder

(Abstract #196575)

Paper Presentation (Asses Dx, Clin Res)

Bolton, James, MD¹; Cox, Brian, PhD¹; Afifi, Tracie, MSC¹; Asmundson, Gordon, PhD²; Sareen, Jitender, MD¹

¹*University of Manitoba, Winnipeg, Manitoba, Canada*

²*University of Regina, Regina, Saskatchewan, Canada*

Few studies have examined factors that may differentiate acute from chronic posttraumatic stress disorder (PTSD). Clarifying the factors associated with chronic PTSD may direct treatment efforts to prevent a persistent illness course. Data came from the National Comorbidity Survey Replication (NCS-R), a large (N = 5692) nationally representative population survey of adults in the United States. Individuals with PTSD (N = 604) were dichotomized into acute and chronic subgroups based on duration of illness of 2 years. The two groups were then compared across a range of sociodemographic factors and mental disorders. Factor analysis was used to group related traumatic events, and the prevalence of these factors were then compared in persons with acute and chronic PTSD. Chronic PTSD was significantly associated with higher rates of mood and anxiety disorders, as well as higher rates of suicidal ideation and attempts. War and terror-related traumatic events did not distinguish acute from chronic PTSD; the single factor grouping differentiating the two groups was childhood

adversity. Individuals with PTSD of greater than two years duration have higher rates of mood and anxiety disorders and suicidal behaviour. Early childhood traumas are potentially more important predictors of chronic PTSD than are combat-related events.

The Impact of Trauma Exposure, Psychiatric Diagnosis, and Resilience on HPA Axis Function

(Abstract #196355)

Paper Presentation (Bio Med, Cul Div)

Weiss, Tamara, MD¹; Avasthi, Ranjan, MD²; Schwartz, Ann, MD¹; Phifer, Justine,¹; Bradley, Rebekah, PhD¹; Ressler, Kerry, MD, PhD¹

¹*Psychiatry, Emory University, Atlanta, Georgia, USA*

²*Psychiatry, Morehouse University, Atlanta, Georgia, USA*

HPA axis dysfunction has been associated with both early life stress and PTSD. This study examined HPA activity as a function of child versus adult trauma history. Data were gathered from 203 participants in a larger study of PTSD in a low SES, urban sample. We found that HPA dynamics varied by exposure to childhood trauma (CT), adult trauma (AT), and childhood plus adult trauma (CT+AT). Trauma history had both independent effects on HPA measures (p=.02) and interaction effects with PTSD (p=.007) and PTSD x MDD (p=.083). Cortisol response to dexamethasone varied as a function of PTSD status in CT+AT participants (but not in CT or AT only participants). We then compared individuals with no history of childhood sexual abuse, early childhood sexual abuse, and late childhood sexual abuse and found that timing of abuse had independent effects on HPA function and interaction effects with MDD and PTSD. HPA dysfunction was more evident in those with early abuse histories. Post-dexamethasone cortisol suppression in non-abused subjects differed significantly from those with early abuse (p=.005) but not late abuse. These data suggest that HPA programming may depend on timing of the trauma. Implications for understanding resilience/risk for trauma-related illness are discussed.

Resource Loss, Personal Values and Distress Among Native Israelis and New Immigrant Terror Victims

(Abstract #196004)

Paper Presentation (Civil Ref, Cul Div)

Fass, Hester, MSW¹

¹*School of Social Work, Bar Ilan University, Ramat Gan, Israel*

Purpose: Since 2000, various terrorist attacks in Israel claimed many lives and wounded thousands, many of them new immigrants. This research aimed to identify the contribution of various factors to the occurrence and severity of PTSD among those wounded in terror attacks. In addition, the consequences of direct exposure to a terrorist attack, following the earlier stressful life-event of immigration, were examined.

Method: Participants included 187 survivors of terrorist attacks, 79 new immigrants and 108 native Israelis. Sociodemographic characteristics, level of exposure, personal values, social support and resource loss were used to predict PTSD occurrence.

Findings: The prevalence of PTSD was 55% among the participants. Resource loss, personal values, level of exposure and social support were identified as predictors of PTSD. Resource loss was identified as the main predictor, but explained significantly higher percentage of the variance among native Israelis than among the new immigrants.

Conclusions: Being wounded in a terrorist attack resulted in persisting PTSD, predicted by various factors. The influence of those factors varied between the native Israelis and the immigrants.

PTSD Treatment Programs: Developing and Implementing Evidence-Based Practice

(Abstract #196140)

Workshop/Case Presentation (Practice, Clin Res) Salon 1, 3rd Floor

Phipps, Kelly A., PhD¹; Chard, Kathleen M., PhD²

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²Cincinnati VA Medical Center, Cincinnati, Ohio, USA

For over 20 years the VA has offered a full continuum of specialty inpatient and outpatient services for veterans experiencing military-related trauma. These programs vary in their structure, with a range of different types of treatments provided. The VA has recently provided substantial resources toward the dissemination and implementation of evidenced-based treatments. These resources offer an opportunity for change and further development of programming in VA PTSD specialty programs. The purpose of this workshop is to provide clinicians with methods to develop and implement evidence-based programming for both inpatient and outpatient PTSD clinics. The information shared can be applied to any agency that provides residential or day treatment for individuals with a diagnosis of PTSD. Presenters will share their experiences and data regarding the development of a residential PTSD and an outpatient PTSD program utilizing evidence-based treatments. The workshop will include: A brief overview of modalities of treatment for PTSD, Program Design (e.g., needs assessment, components of the program), Program Implementation (e.g., administrative, resources), Program Evaluation, and an interactive group discussion for facilitators and participants to generate strategies to use these methods in their own treatment settings.

Burundian Refugee in the U.S.: Mobilizing Protective Resources

(Abstract #196143)

Workshop/Case Presentation (Civil Ref, Cul Div) Salon 3, 3rd Floor

Weine, Stevan, MD¹; Hakizimana, Leonce, BS¹; Landgren, Karine, MSC¹; Gahungu, Athanase, PhD²; Ware, Norma, PhD³

¹University of Illinois at Chicago, Chicago, Illinois, USA

²Educational Leadership, Curriculum and Foundations, Chicago State University, Chicago, Illinois, USA

³Social Medicine, Harvard University, Boston, Massachusetts, USA

Nine thousand Burundian refugees from Tanzanian refugee camps are now being resettled in the U.S. The "1972 Burundians" are mostly Hutu and fled a violent campaign from the Tutsi controlled government. Living in exile in Tanzania for three decades, they experienced ongoing political and criminal violence, sexual assault, poverty, unemployment, dependency, no freedom of movement, family break-up, and poor education. Due to these factors, this refugee group presents important differences from other recent refugees whose resettlement was guided by a conceptualization of refugee trauma that prioritizes recent exposure to political violence (Weine, in press). This workshop applies a preventive mental health model for enhancing protective resources (Weine & Ware, 2007). It identifies community and family protective resources in sociocultural context based upon ethnographic research. Community resources are evident in the churches Burundian refugees quickly joined or formed. Family resources are evident in strong parent-child ties and extended families. Potential interventions for mobilizing protective resources focus on faith-based interventions and parental involvement in education. Presenters will give case examples and encourage discussion involving audience participants that explores approaching Burundian resettlement from a preventive mental health perspective.

A Manualized Group Protocol of Exposure, Cognitive, and Behavioral Treatments for PTSD

(Abstract #196506)

Workshop/Case Presentation (Clin Res, Prev EI) Salons 4-6, 3rd Floor

Castillo, Diane, PhD¹; Keane, Terence, PhD²; Montgomery, Catherine R., MA¹

¹Behavioral Health Care System (116), New Mexico VA Health Care System, Albuquerque, New Mexico, USA

²Boston VA Medical Center, Boston, Massachusetts, USA

The purpose of this workshop is to present a group protocol treatment for PTSD from a recently funded study and will detail how effective therapy interventions—exposure, cognitive, and behavioral—can be provided in structured, small groups. Therapies found most effective for PTSD are exposure and cognitive, with less support for other treatments (Rothbaum, et. al., 2000). Studies have been conducted individually, while most PTSD treatments in VA hospitals are conducted in groups (Garrick, 2000). The literature has shown no difference between specific interventions in groups, including exposure in a group format (Schnurr, et. al., 2003), while support for group exposure was found in a clinical setting (Castillo, 2004). **METHODOLOGY:** Assessment: pre, post, 3-, and 6-month post treatment; between treatment blocks. Procedure: 72 female OIF/OEF veterans positive for PTSD randomized into a three-person, 16-week treatment group or wait-list control. Blocks: Exposure: trauma and safety nets identified, imaginal exposure. Cognitive: didactic cognitive restructuring, writing of beliefs on safety, trust, power/competence, and esteem/intimacy, distortions examined in session. Behavioral: didactic and videotaped role-play assertiveness training, 4 relaxation techniques. Attendees will gain information on the application of evidence-based treatments for PTSD in a manualized treatment group.

Concurrent Session 3
Thursday, November 13
2:00 p.m. – 3:15 p.m.

Trauma and Reparative Justice

(Abstract #196781)

Featured (Sos Ethic, Media Ed) **Grand Ballroom, 4th Floor**

Danieli, Yael, PhD¹; Susan, Hirsch, PhD²; Mones, Paul, JD³;
Laperrière, André, MBA⁴;

¹*Group Project for Holocaust Survivors and Their Children, New York, New York, USA*

²*Institute for Conflict Analysis and Resolution, George Mason University, Arlington, Virginia, USA*

³*Attorney/Consultant, Portland, Oregon, USA*

⁴*The Trust Fund for Victims, Sainte-Foy, Quebec, Canada*

Delineating the meaning of reparative justice in relation to other forms of justice, and beyond reparation per se, this multidisciplinary panel will convey, from the victims' and a lawyer's perspective, their experiences of justice. Missed opportunities and negative experiences in international justice will be examined as a means to better understand critical junctures of trials and victims' role within the totality of the trial process to demonstrate that, if conducted optimally, the justice process can lead to opportunities for healing. Reparative justice clearly requires ongoing training of all professionals, be it judges, prosecutors, lawyers, interpreters, on all aspects of the courts' mandates related to victims, including self-care to counteract vicarious victimization.

The First Blueprint for International Mass Casualty Intervention: 5 Principles to Guide Intervention and Research

(Abstract #195863)

Symposium/Panel (Prev EI, Disaster) **Wabash Room, 3rd Floor**

Hobfoll, Stevan, PhD¹; Ursano, Robert, MD²; Watson, Patricia, PhD³;
de Jong, Joop, MD⁴

¹*Psychology, Kent State University & Summa Health System, Kent, Ohio, USA*

²*Psychiatry, Uniformed Services University of the Health Sciences, Kensington, Maryland, USA*

³*National Center for PTSD, Waikoloa, Hawaii, USA*

⁴*Department of Health, City of Amsterdam, Amsterdam, Holland, Netherlands*

The 5 Principles for Mass Casualty Intervention is the first evidence-based consensus supporting recommendations for intervention during the immediate and the mid-term post mass trauma phases. A worldwide panel of experts was assembled on disaster and mass violence study and treatment to extrapolate from related fields of research, and to gain consensus on intervention principles. They identified five empirically supported, intervention principles that should be contained within intervention and prevention efforts. These are promoting: 1. sense of safety, 2. sense of self- and community-efficacy, 3. connectedness, 4. calming, and 5. hope.

The expert panel offers a distilled, comprehensive blueprint of best intervention practices following major disaster and terrorist attack for the short-term and mid-term period ranging from the immediate hours to several months after disaster or attack.

We will apply the 5 Principles of Mass Casualty Intervention to military and civilian settings. We discuss the international transportability of the 5 Principles, which can be translated to Majority World Cultures and Circumstances if cultural-based knowledge is integrated. How the principles can be used to guide public policy will be considered, as well as a standard for judging and evaluating broad intervention efforts.

Participant Alert: Photos relating to mass casualty may be shown.

Brief Eclectic Psychotherapy for PTSD: New Evidence

(Abstract #195987)

Symposium/Panel (Clin Res, Practice) **Salons 4-6, 3rd Floor**

Schnyder, Ulrich, MD¹; Gersons, Berthold, MD, PhD²; Wittmann, Lutz, PhD³; Nijdam, Mirjam, MSc⁴; Maercker, Andreas, MD, PhD⁵; Mueller, Julia, PhD³; Olf, Miranda, PhD⁶

¹*International Society for Traumatic Stress Studies, Zurich, Switzerland*

²*AMC UVA Dept of Psychiatry, Amsterdam, Netherlands*

³*Department of Psychiatry, University of Zurich, Zurich, Switzerland*

⁴*Academic Medical Center at the University, Amsterdam, Netherlands*

⁵*University of Zurich, Zurich, Switzerland*

⁶*Academic Medical Center, Amsterdam, Netherlands*

Brief Eclectic Psychotherapy (BEP) is a multimodal treatment for PTSD comprising five essentials: psychoeducation; imaginal exposure; writing assignments and mementos; domain of meaning and integration; and a farewell ritual. This symposium presents findings from two recent randomized controlled trials testing BEP versus a minimal attention control group, and versus EMDR.

Brief Eclectic Psychotherapy for PTSD; An Introduction

Brief eclectic psychotherapy (BEP) was developed in the eighties when CBT and EMDR were not available as evidence-based treatments for PTSD. Psychodynamic treatments for PTSD then were well received by patients but did not show a reduction of symptoms. BEP has still as the second part of this 16-session protocolized treatment an important emphasis on discussing how the traumatic event(s) has or have changed the view of oneself and of the world around us. This is called the domain of meaning. In terms of CBT this is called "cognitive restructuring" and the objective is to help the patient learn from the event and to stimulate posttraumatic growth. The elements which are responsible for the reduction of symptoms are the psychoeducation for the patients to understand the symptom in relation to the traumatic event. After two RCT's, BEP has been accepted as an evidence-based treatment within the NICE Guidelines in the UK. Similarities and differences of BEP compared to CBT and EMDR will be outlined.

Posttraumatic Growth and PTSD Symptoms in Response to Brief Eclectic Psychotherapy and EMDR

How posttraumatic growth is related to posttraumatic stress pathology is a matter of ongoing debate. Examining these reactions in response to trauma-focused psychotherapy can help us gain more insight into these phenomena. In this paper, preliminary results are presented from a randomized controlled trial comparing Brief Eclectic Psychotherapy (BEP; n = 70) and Eye Movement Desensitization and Reprocessing therapy (EMDR; n = 70). Participants were outpatients who had a diagnosis of PTSD following various kinds of type I trauma. The measures we applied to assess pre-post differences were SI-PTSD, SCID-I/P, IES-R, and PTGI. Preliminary analyses indicate a significant increase in posttraumatic growth and a significant decrease in PTSD symptomatology for both treatment conditions. Relationships between these variables and differences between treatment conditions are discussed.

Brief Eclectic Psychotherapy for PTSD – A Randomized Controlled Trial

Purpose: We conducted a randomized controlled trial of Brief Eclectic Psychotherapy (BEP) versus a minimal attention control group, trying to independently replicate Gersons et al's findings in a more general trauma population. We applied the seven gold standards outlined by Foa et al. regarding ideal treatment studies of traumatized populations. Primary outcome measure was PTSD symptomatology.

Methods: 39 patients suffering from PTSD following various types of civilian trauma were randomly assigned to either 16 weekly sessions of BEP (n=20) or a minimal attention control group of 16 weeks (n=19). 20 subjects were females, age ranged from 20-74 years. Patients had survived serious accidents (14), violent or sexual assaults (10), childhood trauma (3), war (4), natural

disasters (2), and other traumatic events (6). Patients were assessed pre and post treatment using the SCID, CAPS, and PDS.

Findings: Data collection was only recently finished. A substantial overall reduction of PTSD symptom levels was found. Factors associated with positive outcome will be presented. Conclusions: This is the first RCT of BEP conducted by a research group independent of the center where BEP was originally developed. BEP appears to yield positive results regarding symptom reduction.

Posttraumatic Growth: A Possible Outcome of Brief Eclectic Psychotherapy?

Purpose: Brief Eclectic Psychotherapy (BEP) is designed to not only reduce PTSD symptoms but also to help trauma survivors finding meaning, and discovering a new view of the world and of themselves. In a randomized controlled trial of BEP, we studied posttraumatic growth along with PTSD symptom trajectories over the course of treatment.

Methods: 39 patients suffering from PTSD following various types of civilian trauma were randomly assigned to either 16 weekly sessions of BEP (n=20) or a minimal attention control group of 16 weeks (n=19). 20 subjects were females, age ranged from 20-74 years. Patients had survived serious accidents (14), violent or sexual assaults (10), childhood trauma (3), war (4), natural disasters (2), and other traumatic events (6). Patients were assessed pre and post treatment using the SCID, CAPS, PDS, and the Posttraumatic Growth Inventory (PGI).

Findings: Data collection was only recently finished. PTSD symptom levels decreased, while PGI scores remained stable. The relationship between PTSD symptoms and PG, and other factors associated with PG, will be presented.

Conclusions: BEP does not appear to systematically influence processes of PG. The question of whether the PGI is an adequate outcome measure will be discussed.

Longitudinal Studies Assessing Neurocognitive Functioning in Relation to Trauma

(Abstract #196073)

Symposium/Panel (Bio Med, Clin Res) State Ballroom, 4th Floor

Meewisse, Mariel, MSc¹; Olf, Miranda, PhD¹; Gersons, Berthold, MD, PhD¹; Golier, Julia, MD²; Vasterling, Jennifer, PhD³; Yehuda, Rachel, PhD⁴; Cardenas-Nicolson, Valerie, PhD⁵; Neylan, Thomas, MD⁶

¹Psychiatry, Academic Medical Center University of Amsterdam, Center for Psychological Trauma, Amsterdam, Netherlands

²James J Peters VA Medical Center, Bronx, New York, USA

³National Center for PTSD, Veterans Affairs Boston Healthcare System, Boston, Massachusetts, USA

⁴Mount Sinai School of Medicine, Bronx, New York, USA

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⁶University of California San Francisco, San Francisco, California, USA

Neurocognitive impairments in trauma related disorders (i.e. PTSD and depression), are evident. We will present longitudinal data validating PTSD symptoms as risk factor for attentional deficits, support for a relationship between PTSD and cognition over time, showing deployment-related neuropsychological alterations in soldiers, and showing a relationship between brain atrophy rate and rate of neurocognitive decline in PTSD.

PTSD Symptoms in the Early and Intermediate Aftermath of a Disaster Predict Long-Term Attentional Deficits

Previous studies have shown that posttraumatic stress disorder (PTSD) is consistently associated with attentional deficits. However, very little is known about long-term impairing effects of PTSD symptoms on attentional processing. Therefore, we examined the initial and intermediate impact of a major disaster on attentional processing.

In a community-based sample of adults survivors of the Enschede

fireworks disaster, PTSD and depressive symptom severity measures were administered at 5 time points, between 2-3 weeks and 4 years postdisaster. We administered the paced auditory serial addition task (PASAT) as a measure for attentional processing at 2 and 4 years postdisaster. PTSD symptoms significantly diminished and PASAT performance improved over time. Multivariate linear regression analysis showed that avoidance symptoms as early as 2-3 weeks postdisaster predicted attentional dysfunction at 2 and 4 years postdisaster. Whereas, at 1,5 years postdisaster severity of reexperiencing symptoms predicted attentional dysfunction 2 and 4 years postdisaster. Thus, depending on the stage postdisaster, particular PTSD symptom clusters indicate which survivors function cognitively less on the long term. Although PTSD symptoms decreased over time, those survivors with early PTSD symptoms do risk falling behind in work or school because of attentional problems years after the disaster.

Longitudinal Brain Assessment of Cognitive Performance in Holocaust Survivors

Background: There is evidence that stress and PTSD may accelerate age-related cognitive decline. To examine the relationship of PTSD to cognition over time we studied Holocaust survivors (n=28) and comparison subjects (n=19) five years after they had undergone a memory assessment which included paired-associate learning and the California Verbal Learning Test (CVLT).

Results: Holocaust survivors with PTSD showed a diminution in PTSD symptom severity as measured by the CAPS ($t = 2.99$, $df = 12$, $p = .011$) but also manifested a decline in paired associates learning (related word pairs: $t = 2.87$, $df = 13$, $p = .013$; unrelated word pairs: $t = 2.06$, $df = 13$, $p = .060$). In contrast, on the CVLT, the Holocaust survivors with PTSD showed improved performance which correlated with symptom improvement; PTSD group differences in the CVLT at follow-up were no longer evident.

Conclusions: The discrepancy in the pattern of performance suggests that aging and clinical state may have an impact on different aspects of memory function affected in PTSD.

Neuropsychological Outcomes of the Iraq War: One-Year Follow-Up of Active Duty Soldiers

Initial findings from the Neurocognition Deployment Health Study (NDHS) indicated that soldiers assessed before deployment and within 90 days of return from Iraq displayed deployment-related neuropsychological alterations. Whether such changes persist over time or remit in the absence of subsequent war-zone exposure remains unknown. To this end, we examined the neuropsychological performances of 164 NDHS cohort members who remained in active duty status 1 year following deployment and who participated in assessments at pre-deployment (Time 1), post-deployment (Time 2), and 1-year follow-up (Time 3). We compared these "early deployers" to 104 cohort members who were also assessed at Time 1 but subsequently deployed between Time 2 and 3 ("late deployers"). Results revealed significant time by group quadratic interactions on measures of verbal ($p = .001$) and visual ($p < .0001$) memory and sustained attention ($p = .009$). The pattern of results suggested partial return to baseline for early deployers during the follow-up period, whereas performance trends were less favorable between Time 2 and 3 (over deployment) in late deployers. PTSD symptoms observed shortly after return from Iraq did not predict neuropsychological performance at 1-year follow-up; however, attentional errors and PTSD symptom severity measured concurrently at 1-year follow-up were positively correlated ($p = .015$).

Longitudinal Brain Atrophy and Neurocognition in PTSD

Our purpose was to understand the relationship between brain atrophy rate and rate of neurocognitive decline, using voxel-wise morphometric methods. Brain magnetic resonance imaging, clinical, and neuropsychological evaluations were conducted on 28 PTSD+ (CAPS: 60 „b 17, 50 „b 6 yrs) and 25 PTSD- (CAPS: 4 „b 5, 52 „b 6 yrs) patients; testing was repeated after 2.8 „b 0.6 yrs. Maps of longitudinal brain change in standard space were created using nonlinear registration methods. These maps were dependent variables in linear regression models that explored the location

and extent of anatomical variation related to independent variables such as PTSD severity or change scores on verbal, visual, and working memory measures. We observed that longitudinal brain change in the frontal and anterior temporal cortex was related to change in CAPS score; tissue recovery was observed in patients with decreasing PTSD severity and greater tissue loss in patients with increasing PTSD severity. Verbal memory decline was related to greater atrophy rate in the region surrounding posterior cingulate, and visual memory decline was related to posterior temporal and parietal white matter regions. In conclusion, different patterns of longitudinal brain change underlie the clinical and cognitive changes observed in PTSD over time.

Symptom Clusters, Comorbidities, Provider Detection, and Preference-Weighted Health Status of PTSD

(Abstract #196103)

Symposium/Panel (Practice, Asses Dx) **Adams Ballroom, 6th Floor**

Freed, Michael C., PhD., EMT-B¹; Yeager, Derik E., MBS²; Magruder, Kathryn M., MPH, PhD²; Liu, Xian, PhD²; Gore, Kristie L., PhD¹; Engel, Charles C., MD, MPH¹

¹Deployment Health Clinical Center / Department of Psychiatry, Walter Reed Army Medical Center / Uniformed Services University of the Health Sciences, Washington, District of Columbia, USA

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In this symposium, we examine PTSD symptom criterion clusters in veterans and how the predominance of these clusters in patients relates to 1) medical and psychiatric morbidity; 2) patient factors that influence provider recognition of PTSD; 3) preference-weighted health status.

Is There a Link Between PTSD Symptom Clusters and Medical and Psychiatric Morbidity?

Based on primary care rosters from four Southeastern VAMCs, a total of 1076 randomly sampled primary care patients were administered the PCL and queried about socio-demographic information. These data were merged with ICD9 diagnoses from the VISN7 corporate database. Complete data were available for 879 patients. The 17 DSM-IV symptoms from the PCL were grouped into three clusters (DSM-IV criteria B, C, and D). PCL scores were then summed, within each cluster, and divided by the total PCL score. Tertiles were assigned based on the distribution of scores within each cluster. ICD9 codes were aggregated and collapsed into medical and psychiatric diagnoses. In general, men were more likely to endorse a higher proportion of B and D cluster symptoms and women a higher proportion of cluster C. Symptom endorsement was otherwise evenly distributed by age and race. Of the major medical diagnoses examined, only hypertension demonstrated a predominant association with one symptom cluster, cluster D. This suggests that patients endorsing the highest tertile of D cluster symptoms were about 2.4 times more likely to have hypertension than patients in the lowest tertile, controlling for clusters B and C. Individual symptom clusters were not singly associated with any psychiatric comorbidity.

Are PTSD Symptom Patterns Related to Primary Care Provider (PCP) Diagnosis of PTSD?

This presentation examines the impact of PTSD symptom patterns on primary care provider (PCP) recognition of PTSD. Based on a random sample of primary care VA patients from 4 hospitals, we assessed PTSD with the CAPS and PCL; we also collected socio-demographics, functional status, and medical record diagnoses for both psychiatric and medical illnesses. Complete/usable data were available for 819 patients, of whom 98 (12%) met criteria for PTSD. Of these, 42 (43%) were correctly diagnosed by their PCP. PCL

responses were grouped into symptom clusters corresponding to DSM-IV-TR B, C, and D criteria, and the clusters were tertiled. After adjustment for age, gender, race, and warzone service, analyses showed that patients in the upper two tertiles for both criteria B (reexperiencing) and D (increased arousal) were more apt to have been recognized than patients in the lowest tertiles. Thus, providers tend to identify the more classical symptoms of PTSD. Given the high rates (>50%) of non-detection of PTSD in primary care, screening instruments and provider education may be helpful strategies to improve detection of atypical presentations of PTSD.

Preference-Weighted Health Status in Veterans With PTSD

Unlike symptom severity and generic quality of life measures, preference-based outcomes are useful for policy and medical decision making because they include assessments of "value" or "worth" of disease states like PTSD. Preference-weighted health status (PWHS) is measured on a scale between anchors of death (equal to 0) and perfect health (equal to 1). We present the relative contributions to decrements in veteran PWHS from demographic variables, PTSD diagnosis and severity, and the co-occurrence of other mental health disorders. We developed a regression model to predict PWHS from a random primary care sample 811 veterans (11.5% diagnosed with PTSD). Responses from the PTSD checklist, Clinician Administered PTSD Scale, Mini International Neuropsychiatric Interview, and Medical Outcomes Survey Short Form-36 (SF-36) were used along with previously published preference-weights for SF-36 defined health states. The model predictors accounted for 38% of PWHS variance, with a PTSD diagnosis reducing PWHS by 0.08 (95%CI of the regression coefficient: 0.02, 0.14). PTSD severity, co-occurring mental health disorders, and demographic variables also significantly contribute to PWHS. This is the first study to present PWHS in persons with PTSD. PWHS in this study can be helpful for future cost-effectiveness studies of PTSD treatments.

Co-Occurring Partner Violence and Mental Health: Novel Settings for Identification and Treatment

(Abstract #196157)

Symposium/Panel (Clin Res, Asses Dx) **Salons 7-9, 3rd Floor**

Talbot, Nancy, PhD¹; Bryant-Davis, Thema, PhD³; Chaudron, Linda, MD, MS¹; Cerulli, Catherine, JD, PhD¹; Krupnick, Janice, PhD²

¹Department of Psychiatry, University of Rochester School of Medicine and Dentistry, Rochester, New York, USA

²Department of Psychiatry, Georgetown University, Washington, District of Columbia, USA

³Graduate School of Education and Psychology, Pepperdine University, Valley Village, California, USA

Intimate partner violence (IPV) is under-reported by women in community settings and concurrent mental health burdens are undertreated. This symposium features mental health interventions in real-world settings with women affected by IPV. Intervention results from a pediatric clinic, family court, and community mental health center will be shared.

Psycho-Social Risk Factors, Intimate Partner Abuse, and African American Women

When examining the experiences of diverse women, researchers find that African American women are among those at greater risk of partner abuse. The purpose of this study was to explore psycho-social factors that may influence intimate partner abuse experiences of African American women. This study is based on a national sample of African American mothers in The Fragile Families and Child Wellbeing Study, which is a study based on a cohort of 4,898 women who gave birth in 20 large U.S. cities. 44% of the sample is African American. The measure which was utilized is the interview questionnaire from the Fragile Families Project. A series of cross-tabular analyses were used to assess whether partner abuse was predicted by the previously listed psycho-social factors. Chi-square statistics were used to determine significance of crosstab results. The findings indicate that living in

7 4
Thursday: 2:00 p.m. – 3:15 p.m.

unsafe, impoverished neighborhoods, older age, and endorsement of traditional gender roles are related to higher instances of partner abuse of African American mothers. This project advances the literature by illuminating the influences of psycho-social risk factors in the lives of African American women. This project was funded by the Robert Wood Johnson Foundation's New Connections Initiative.

Evidence-Based Depression Treatment in Community Care: IPT for Women With Trauma Histories

In community mental health settings depressed women with interpersonal trauma histories are a large segment of the patient population. Yet evidence-based therapies for depression are rarely studied in community settings with women in violent relationships, who experienced childhood abuse, and have high psychiatric and socioeconomic burden. Interpersonal Psychotherapy (IPT) is an evidence-based depression treatment we are examining among women in a community mental health center (CMHC) who have major depression and sexual abuse histories. The majority also suffer chronic depression, PTSD, and intimate partner violence. Findings from two treatment studies in a CMHC will be presented: an uncontrolled pilot study of modified IPT (n=36) and a randomized trial of modified IPT compared to usual care (n=70). Participants were predominantly low-income, minority-group members, and single mothers. In the pilot study we found that women experienced a decline in depressive symptoms and improved mental-health functioning but did not significantly improve in overall social functioning. Results from the randomized controlled trial will be presented. We will address how comorbid PTSD and intimate partner violence affected women's ability to engage in treatment and their treatment outcomes. Modifications to IPT that may assist its transport to community mental health care will be discussed.

Exploring the Overlap of Intimate Partner Violence and Perinatal Depression

Perinatal depression affects 10-20% of new mothers and up to half of low-income mothers. Intimate partner violence (IPV) affects 15% of pregnant women with the rates among postpartum women essentially unknown. Both depression and IPV are under-reported by women, poorly detected by providers, and their relationship is not yet established. Our study examined IPV prevalence in a sample of low-income mothers attending infant well-childcare visits. Women (n=198) attending an urban pediatric clinic in the postpartum year completed a standardized psychiatric interview and a series of questionnaires, including a self-report of IPV over their lifetime, during pregnancy, and in the postpartum period. We examined associations between depression and IPV. Preliminary results revealed that 28% of participants reported IPV threats or assaults. Of those reporting IPV, 40% reported events during pregnancy and 13% reported events in the first postpartum month. Injuries ranged from minor cuts and bruises to broken bones and organ damage. Women who reported threats of physical harm by intimate partners had significantly more depressive symptoms than those who did not endorse threats. Implications for IPV assessment and interventions in pediatric settings will be discussed.

Linking Court-Based Intimate Partner Victims With Mental Health Services: Will They Connect?

Many studies document high correlations between intimate partner violence (IPV) and mental health burden, yet few studies have been able to make causal connections or determine temporal ordering of violence and mental health symptoms. The current study assessed mental health symptoms among IPV victims filing for protection orders and reassessed symptoms 1 week and 6 months post-court appearance. We examined whether the issuance or denial of protection orders mediated women's subsequent depression. We will also report on a randomized controlled trial in the court that linked IPV victims to mental health services. A sample of 190 women, average age 32 years, half minority-group members, were randomized to one of three referral groups: standardized pamphlet for mental health services, an individualized assessment and printed referral, or an individual

assessment and printed referral coupled with a brief patient engagement. Women's mental health service use at 6 months post-intervention will be reported. Finally, the implications for court-based mental health interventions for women involved in IPV will be explored.

Participant Alert: The content of the presentations in this symposium addresses violence against women and children and may be distressing for some people.

Measuring Fidelity in Treatment Implementation: Validity vs. Practicality

(Abstract #196254)

Symposium/Panel (Clin Res, Practice) **Monroe Ballroom, 6th Floor**

Hanson, Rochelle, PhD¹; Saunders, Benjamin, PhD¹; Ruggiero, Kenneth, PhD²; Kolko, David, PhD²; Amy, Herschell, PhD³; Berliner, Lucy, MSW⁴

¹Medical University of South Carolina, Charleston, South Carolina, USA

²University of Pittsburgh, Pittsburgh, Pennsylvania, USA

³Western Psychiatric Institute and Clinic, Pittsburgh, Pennsylvania, USA

⁴University of Washington, Seattle, Washington, USA

This presentation will describe common fidelity measurement approaches used in efficacy studies, effectiveness studies, and implementation projects, measurement validity issues associated with each approach, and the costs and logistics of using them in community service agencies. Two NIMH-funded studies will be presented, highlighting different methods of assessing clinician fidelity to evidence-supported trauma-focused treatment interventions as well as the challenges inherent in conducting this type of research.

Fidelity in Treatment Implementation: Overview

A crucial issue when attempting to implement evidence supported trauma treatments in community service settings is how to measure therapist fidelity to the treatment model in a scientifically valid yet practical manner, given the realities of front-line agency practice. Scientific validity arguments suggest that therapist fidelity to a treatment model can only be measured through relatively complex methods such as live monitoring and rating of actual sessions by treatment experts or by taping of sessions and coding by trained observers. Unfortunately, the costs of using these measurement methods in terms of effort, expertise, money, and staff time may be well beyond the capacity of implementing service organizations. However, easier and less costly approaches such as therapist self-report or a client completed treatment module checklist are considered far less accurate. This presentation will describe common fidelity measurement approaches used in efficacy studies, effectiveness studies, and implementation projects, measurement validity issues associated with each approach, and the costs and logistics of using them in community service agencies. Balancing the issues of validity and practicality in fidelity measurement in implementation projects will be discussed.

Assessing Treatment Fidelity in Trauma-Focused Treatment With Children

Investigation of the dissemination and effectiveness of evidence-based interventions is an important, but challenging area of research. We are conducting an ongoing NIMH-funded study (PI: Rochelle F. Hanson) to examine transport of an evidence-based treatment to community-based settings as a function of two different training modalities (i.e., workshop versus supervision). The "BRidGE" project (Bridging the Research Gap Effectively) utilizes a single subject multiple baseline design, with community-based clinicians, to measure fidelity to a protocol with demonstrated efficacy in the treatment of violence-exposed youth: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006). The primary measure of clinician fidelity is coded audiotapes of treatment sessions. Clinicians (n=17) also completed a self-report measure about their use of TF-CBT components in their treatment sessions over the prior four months. We have coded audiotapes of treatment sessions and

completed self-report questionnaires for seven of these clinicians. In this paper, we will present data examining associations between clinicians' self-reported use of TF-CBT components as measured by the self-report measure, compared to the coded audiotapes of treatment sessions. The paper will conclude with recommendations for future work in this important and challenging line of research.

Fidelity in the Field: Adherence to AF-CBT in an Effectiveness Trial
The Partnerships for Families project is an NIMH-funded study designed to evaluate the effectiveness of Abuse-Focused Cognitive Behavioral Therapy (AF-CBT), an evidence-based treatment for child physical abuse. Counselors from 10 community agencies have been randomized to AF-CBT or Treatment or Usual. Participating practitioners can enroll families they are treating who have a caregiver experiencing or who is at risk for experiencing difficulties with the use of physical discipline. AF-CBT practitioners receive 32 hours of workshop training and 20 hours of case consultation over 6 months. We describe in this presentation our initial efforts to describe, measure, and enhance adherence to AF-CBT. This will include a description of our samples and data collection methods, the scales developed for rating AF-CBT use, and several issues that were addressed in the construction of these scales. We will report data based on the training (% agreement = .78 - 1.00; M = .87) and implementation phases including correlates of high adherence. Issues of relevance to the field, such as coder training and preparation, the need for ongoing quality control checks, and the use of feedback for practitioners, will be discussed. Based on this initial experience, specific recommendations for research and practice will be reviewed.

Papers
Novel Interventions for PTSD

Salon 1, 3rd Floor

Chair: Ronald Murphy, PhD,
International Society for Traumatic Stress Studies, Florence, South Carolina, USA

PTSD: Is the Internet of Any Use?
(Abstract #196273)

Paper Presentation (Media Ed, Res Meth)

Herbert, Christophe, MA¹; Brunet, Alain, PhD²
¹*Psychiatry, Douglas Hospital Research Centre, Montréal, Québec, Canada*
²*Psychiatry, McGill university, Montréal, Québec, Canada*

In 2006, 113 millions Americans searched the Internet for health-related information and 22% of them searched specifically for information on mental health (Fox, 2006). The goal of the present study was to understand, classify and offer prototypical examples of the type of applications that can be found currently on the internet with respect to PTSD. We conducted a thorough web and literature review with keywords like «Internet», «Web», «PTSD» and «trauma» using the Pubmed, PsycInfo and PILOTS databases. 1. Most typically the sites provide basic information on the disorder for the general public or for trauma survivors. 2. Internet can also provide a way for victims to express themselves about their feelings (blogs, chat, ...). 3. Other sites propose an on-line 'diagnostic' tool which can serve a useful triage function and lead to referral. 3. The effectiveness of on-line secondary and tertiary prevention intervention (i.e. debriefing-like interventions and psychotherapy) has also been examined in a number of RCTs. 4. Some organizations are also using the internet to develop e-learning programmes for their students or for professionals. 5. Recent papers also report on the use of internet to conduct trauma research. The benefits and limitations of those applications will be discussed and future directions will be outlined.

Development and Pilot-Test of a Group Intervention for Traumatized Homeless Women

(Abstract #196179)

Paper Presentation (Clin Res, Commun)

Rayburn, Nadine, PhD¹; Gilbert, Mary Lou, MA, JD¹; Wenzel, Suzanne, PhD¹; Jaycox, Lisa, PhD²; Golinelli, Daniela, PhD¹
¹*RAND Corporation, Santa Monica, California, USA*
²*RAND Corporation, Arlington, Virginia, USA*

Homeless women experience high levels of trauma and posttraumatic stress disorder (PTSD). Although successful cognitive-behavioral interventions for PTSD exist, none specifically address the needs of homeless women. This paper describes a multi-phase study that tailored cognitive-behavioral treatment components for PTSD to the needs of homeless women. Throughout the development of our group intervention we conducted focus groups to obtain input from homeless women living in shelters and from providers of services to homeless women. Our goal was to maximize the relevance of the cognitive-behavioral group treatment and minimize the barriers to access.

The final phase of the study consists of a pilot test of the intervention with homeless women who have subthreshold PTSD. 32 women are randomly assigned to either the PTSD intervention condition or to an assessment-only waitlist control condition. We assess changes in PTSD and depression symptoms as a function of participation in the intervention. This presentation summarizes data from our focus groups collected during the development of the treatment, as well as outcome data from our pilot study.

Treating PTSD With a Time-Limited Psychodynamic Approach: Manual Development and Efficacy Data

(Abstract #196222)

Paper Presentation (Clin Res, Child)

Shafraan, Naama, MA¹; Rosenbach, Lea, MA²; Wolff, Maya, PhD³; Harish-Avidan, Shelly, MA³; Foa, Edna, PhD⁴; Gilboa-Shechtman, Eva, PhD⁵
¹*Psychology, Bar Ilan University, Jerusalem, Israel*
²*Psychology, Student Counseling Center, Ramat Gan, Israel*
³*Psychology, Bar Ilan University, Ramat Gan, Israel*
⁴*University of Pennsylvania, Philadelphia, Pennsylvania, USA*
⁵*Psychology, The Gonda Multidisciplinary Brain Research Center, Bar Ilan University, Ramat Gan, Israel*

Time-limited psychodynamic therapy (TLDP) principles are often used as a prism through which themes from the patient's life are formulated into a central therapeutic issue. to date, there are no disorder-specific manuals based on this approach. We developed a TLDP manual for treating adolescent victims of single event traumas suffering from PTSD based on the work of James Mann (1973) and Lester Luborsky (1984). This manual includes 21 sessions: 3 initial sessions of central issue formulation and 18 "working through" sessions. The central issue focuses on an unresolved conflict, the patient's negative self-image and associated emotions. It is formulated to account for the impact of trauma. The working-through sessions are developmentally adjusted to enhance adolescents' involvement in treatment. Nineteen adolescents (13 girls, ages 11-17, mean 13.8 years), victims of a single traumatic event (e.g., terror, sexual and physical assaults) began treatment according to this manual. Based on self report measures, the effect size of completers (N=15) was 1.02 for Posttraumatic, 1.08 for depressive and 1.49 for general anxiety symptoms. A TLDP manual can be effective in reducing emotional distress among adolescent PTSD sufferers. Implications for the understanding of the mechanisms of therapeutic change, and psychological vulnerability underlying PTSD, are discussed.

Effect of a Motivation Intervention on Treatment Engagement Process Variables Among PTSD Veterans

(Abstract #196327)

Paper Presentation (Clin Res, Mil Emer)

Murphy, Ronald, PhD¹; Thompson, Karin, PhD²; Murray, Marsheena, BA³; Quaneecia, Rainey, BA⁴; Uddo, Madeline, PhD⁵

¹International Society for Traumatic Stress Studies, Florence, South Carolina, USA

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³Kent State University, Kent, Ohio, USA

⁴Washington State University- Pullman, Pullman, Washington, USA

⁵Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana, USA

This presentation describes early results from a randomized trial of the PTSD Motivation Enhancement (PME) Group, designed to increase problem recognition and treatment engagement among combat veterans. Previously presented findings show superior attendance in outpatient PTSD treatment for PME Group participants compared to controls. Presented here are findings regarding predicted differences on process variables. Combat veteran participants were randomly assigned to either four sessions of the PME Group (n=60) or psychoeducation (PE Control, n=54) in the second month of a 12-month VA outpatient PTSD program. A number of treatment engagement variables were assessed at the end of participants' attendance at the PME Group or control group condition. Significant t-tests and other analyses indicated that compared to controls, PME Group participants more often decided that problems previously identified as "Might Have" were definitely a problem, were higher on Task and Bond subscales of the Working Alliance Inventory for, and were more satisfied with, their just-completed group, gave higher ratings of overall treatment relevance, and gave higher ratings of endorsement for some items of responsibility-taking for addressing problems. Limitations and implications for PTSD treatment engagement and motivation interventions are discussed.

Papers

PTSD and Conflict-Affected Children

Crystal Room, 3rd Floor

Chair: Wietse Tol, MA,
Public Health & Research, HealthNet TPO,
Amsterdam, Netherlands

School-Based Intervention for War-Affected Children: Randomized Trials in Burundi and Indonesia

(Abstract #196256)

Paper Presentation (Clin Res, Civil Ref)

Tol, Wietse, MA¹; Komproe, Ivan, PhD¹; Susanty, Dessy, MA²; Ndayisaba, Aline, MA³; de Jong, Joop, PhD⁴

¹Public Health & Research, HealthNet TPO, Amsterdam, Netherlands

²CWS Indonesia, Jakarta, Indonesia

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⁴VU University Amsterdam, Amsterdam, Netherlands

The evidence base of mental health treatments for people exposed to complex emergencies in low- and middle income countries is weak (Patel et al, 2007). We aimed to evaluate treatment outcome of a school-based psychosocial intervention in civil war-affected northern Burundi and communal violence-affected Central Sulawesi, Indonesia.

Children, in randomly selected schools, were screened with symptom checklists for posttraumatic stress symptoms, anxiety and depression and subsequently enrolled in a treatment (Burundi n=153, Indonesia n=182) or waitlist condition (Burundi n=176,

Indonesia n=221). Child and parent assessments with contextually adapted standardized instrumentation, including symptomatology, resilience variables, and functioning, took place before, right after, and 6 months after treatment. Treatment consisted of the manualized 15-session Classroom-based Intervention (CBI; Macy et al, 2003), which emphasizes integrating cognitive-behavioral techniques with cooperative play and creative-expressive exercises.

Intent-to-treat analyses revealed significantly larger gains of moderate effect sizes 6 months after treatment on PTSD (Cohen d=.44) and Hope (Cohen d=.38) in Indonesia, but similar gains over time in the treatment and waitlist conditions in Burundi. The presentation will address the research and treatment implications of these findings.

Participant Alert: Presentation will refer to war events children were exposed to and their consequences for mental health.

Use of Subjective Measures in the Assessment of Terrorism Among Children in Southern Darfur

(Abstract #196497)

Paper Presentation (Child, Asses Dx)

Morgos, Dorothy, PhD¹

¹Yale School of Medicine, New Haven, Connecticut, USA

The use of children's drawings and narratives aimed at addressing the effects of terrorism remain scarce in the literature, particularly on the African continent. Baseline assessment was conducted to determine the prevalence of psychological distress among a randomly selected sample of 331 children ages 6-17 living in three IDP camps. The children were interviewed in Arabic using: Demographic profile, War Events Inventory, Child Posttraumatic Stress Reaction Index, Child Depression Inventory, Expanded Grief Inventory, Children's drawings and Trauma narratives. The majority of participants were exposed to high levels of war related violence, with no significant differences for the types of war exposure. total of 75% of the children met the *DSM-IV* criteria for PTSD, while 38% exhibited symptoms of clinical depression, and 20% reported grief reactions. Results from children's drawings and trauma narratives provided implications for future assessment and interventions. Importance of incorporating subjective measures and translation of cultural and age differences in expressing traumatic reactions to terrorism are discussed in terms of providing culturally sensitive assessments and interventions without compromising the empirical integrity. The ethical and empirical challenges of using subjective measures in the assessment of terrorism are discussed.

State By State Partnership in Support of Returning Combat Veterans and Their Families

(Abstract #196034)

Workshop/Case Presentation (Commun, Prev EI) Salon 3, 3rd Floor

Straits-Troster, Kristy, PhD¹; Kudler, Harold, MD¹; Goodale, Bob, MBA²; Oliver, John, DMIN³

¹Dept. of Psychiatry & Behavioral Sciences, Durham VAMC & Duke University, Durham, North Carolina, USA

²Citizen Soldiers Support Program, UNC-Chapel Hill, Chapel Hill, North Carolina, USA

³Chief, Chaplain Service, Durham VAMC, Durham, North Carolina, USA

This interactive workshop will demonstrate the need for community collaboration in supporting returning combat veterans and their families and will provide specific examples of successful innovations and partnerships. In the United States, the state is the ideal functional unit for post deployment community intervention. We will provide a template for partnering with leadership at the state level, including: National Guard, Department of Defense

(DoD), Department of Veterans Affairs (VA), state and community mental health and substance abuse services, state veterans service officers, clergy/chaplains, employers, educational systems and veterans service organizations. Specific examples include: 1) State summit meetings; 2) New dissemination channels for outreach and knowledge management; 3) Expedited access to care in rural communities through targeted primary care provider support and training for child and family therapists; and 4) Community clergy training through clinical pastoral education networks. Participants are encouraged to share their local successes and challenges and to consider new ways to partner across communities.

Creating a Trauma-Informed Child Welfare System: The Child Welfare Trauma Training Toolkit

(Abstract #196162)

Workshop/Case Presentation (Media Ed, Child) Salon 2, 3rd Floor

Ko, Susan, PhD¹; Sprague, Caryll, MA¹; Conradi, Lisa, PsyD²; Wilson, Charles, MSW³

¹*UCLA Neuropsychiatric Institute and Hospital, National Center for Child Traumatic Stress, Los Angeles, California, USA*

²*Chadwick Center for Children and Families, San Diego, California, USA*

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In a given year, perhaps one million children come to the attention of the child welfare system. Many are victims of abuse or neglect, live with caregivers who are impaired, and deal with school and community violence as a fact of life. Increasing knowledge and building skills among caseworkers and other child welfare personnel is critical to identifying and providing early intervention for children traumatized by maltreatment and other stressors. The Child Welfare Trauma Training toolkit was developed by the National Child Traumatic Stress Network and partners and the purpose is to provide training for public child welfare professionals that enhances their understanding of the impact of trauma on the development and behavior of children. The training is designed to build knowledge about when and how to assess for trauma, intervene directly in a trauma-sensitive manner, and provide strategic referrals for evidence-based services. The toolkit has been created as a train-the-trainer manual and includes the Trainer's Guide, Slide Kit, Supplemental Handouts (e.g., vignettes, Child Welfare Trauma Referral tool), audioclip, and the Comprehensive Guide. The workshop will walk participants through the entire manual and highlight tips for how to effectively use the activities in the manual during a training (e.g., vignettes, videos, evaluation tools).

**Concurrent Session 4
Thursday, November 13
3:30 p.m. – 4:45 p.m.**

Cognitive Therapy for Posttraumatic Stress Disorder
(Abstract #197588)

Master (Practice, Clin Res) Monroe Ballroom, 6th Floor

Clark, David, DPHIL¹

¹*Institute of Psychiatry, King's College London, London, United Kingdom*

Ehlers and Clark (2000) proposed a cognitive model of the development and maintenance of PTSD that specifies three main therapeutic targets. These are: 1) reducing re-experiencing by elaborating the trauma memory and discriminating between current triggers and cues that were present at the time of the Trauma, 2) identifying and modifying excessively negative appraisals of the trauma and/or its sequelae; and 3) dropping problematic maintaining cognitive and behavioural strategies. A novel cognitive therapy (CT) programme that specifically focuses on these targets was developed and tested in four randomized controlled trials and two dissemination studies. Taken together these studies show that the treatment is: acceptable to patients (low drop-out rate), effective (large controlled effect sizes relative to no-treatment), and specific (superior to an alternative, equally credible psychosocial treatment). The trials have established the treatment's efficacy for PTSD following single and multiple traumatic events in adulthood including those arising from civil conflict and terrorism. The dissemination studies have shown that the treatment can be transported to everyday community clinical settings without loss of effectiveness. Finally, an intensive version of the treatment that concentrates the therapeutic work into a single week has been developed and shown to be similarly effective.

This presentation describes and illustrates the key therapeutic manoeuvres in CT for PTSD. The overall treatment programme includes elements that are common in other empirically validated CBT programmes (e.g. imaginal reliving and cognitive restructuring) as well as novel features. The presentation concentrates on the more novel features, which are illustrated with video tapes of live treatment sessions. Key manoeuvres include: 1) identifying triggers for intrusive memories and discriminating between these triggers and the original trauma using experiential work; 2) working on linking trauma hot spots with updating information and facilitating elaboration; 3) re-scripting intrusive images; and 4) dealing with a wide range of problematic behavioural and cognitive strategies.

Participant Alert: Video tapes of treatment sessions in which patients exhibit distress will be shown.

**SOLDIERS OF CONSCIENCE:
Award-Winning Documentary About Killing in War**
(PBS Broadcast – Oct 2008)

(Abstract #196644)

Media Presentation Crystal Room, 3rd Floor

Weimberg, Gary, BA¹; Ryan, Catherine, MA¹; Maguen, Shira, PhD²
¹*SOLDIERS OF CONSCIENCE, Luna Productions, Berkeley, California, USA*

²*PTSD Program (116P), San Francisco VA Medical Center, San Francisco, California, USA*

This presentation introduces SOLDIERS OF CONSCIENCE as a media resource for trauma specialists, social workers, and clergy serving soldiers, veterans, and their families. SOLDIERS OF CONSCIENCE operates with a central premise: every soldier is a soldier of conscience. Told entirely by soldiers, this documentary film reveals that the act of killing another human being is one of

the most traumatic experiences in life. Be they sincere war fighters or sincere conscientious objectors, all soldiers must face this burden of conscience – and the serious moral and psychological consequences it may entail. Made with an official assistance agreement from the US Army, *SOLDIERS OF CONSCIENCE* is an intimate, personal and honest film about killing in war and its impact on the young men and women who serve our nation. The filmmaker will screen an extended excerpt and participate in discussion about issues raised by the film, as well as potential uses in clinical, counseling, and faith settings. Such uses include screening the film as:

- a professional development tool for mental health staff
- a counseling resource for families of soldiers and veterans
- a therapeutic resource (where appropriate) for veterans dealing with PTSD, depression, or other issues, and
- a community resource for congregations seeking to support veterans and their families.

Participant Alert: *SOLDIERS OF CONSCIENCE* depicts brief, but graphic images of war, including: dead and injured human bodies, gunfire and loud explosions.

Not to Forget Culture—Studies on the Development and Maintenance of PTSD

(Abstract #195872)

Symposium/Panel (Cul Div, Res Meth)

State Ballroom, 4th Floor

Maercker, Andreas, MD, PhD¹; Norris, Fran, PhD²; Hinton, Devon, MD³; de Jong, Joop, MD⁴; Hobfoll, Stevan, PhD⁵

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Research on the etiology of PTSD has identified several biopsychosocial factors that contribute to its development and maintenance. Among the variables that have only rarely been investigated are cultural factors. Studies using samples from different cultures living in their home countries (China, Germany) or as immigrants to the US (Vietnamese, Cambodians) are presented.

PTSD in the Vietnamese Community Following Hurricane Katrina

One year after Hurricane Katrina devastated New Orleans, we assessed 82 members of the Vietnamese community who had participated in a larger study of immigration weeks before the disaster struck. PTSD was assessed with the Vietnamese version of the Composite International Diagnostic Interview for *DSM-IV*, the same measure that was used in the National Latino and Asian American Study (NLAAS), conducted in the United States. Despite high trauma and loss, only 5% of the sample met all criteria for PTSD related to Hurricane Katrina, but 21% met criteria for partial PTSD. Avoidance/numbing symptoms did not form a coherent cluster and were seldom confirmed, but intrusion, arousal, and interference were common. Sex, age, education, severity of exposure to the flood waters, property loss, and subjective trauma were independently related to PTSD symptoms. Katrina-related PTSD symptoms were highest among participants who had high Katrina exposure in combination with prolonged stays in transition camps during emigration. Factors that may have contributed to the resilience of the Vietnamese community are discussed.

The Culturally Sensitive Assessment of Trauma-Related Disorder Among Refugees: A Cambodian Example

A culturally sensitive instrument to assess traumatized Cambodian refugees will be described. The assessment instrument has scales that assess (1) *DSM* PTSD symptoms, (2) somatic complaints, including culturally specific somatic complaints, (3) sleep complaints not assessed in the *DSM* criteria (e.g., sleep paralysis), (4) agoraphobia-type cultural syndromes (e.g., “car sickness” and

“people sickness”), (5) somatic-symptom-focused cultural syndromes (e.g., “weak heart,” “wind attacks,” and “hot inside”), and (6) emotion-focused cultural syndromes (e.g., “thinking too much” and “parched mind”). Through an analysis of a large sample (over 200 patients), the relationship between the *DSM*-based PTSD scale and the other scales (and their items) will be discussed.

Can Culture and Values Co-Construct PTSD? A Study in China and Germany

We define “culture” not only by nationality as in cross-cultural research but also by basic value orientations. We conducted a cross-cultural comparison with Chinese and German crime victims and included an assessment of value orientation according to Schwartz’s (1994) theory of cultural values. Traditional (conformity, benevolence, customs orientation) and modern values (achievement, hedonism, stimulation), traumatic exposure, PTSD symptoms, and two psychosocial mediator processes (disclosure intentions, social acknowledgment as a victim) were assessed. 130 Chinese and 151 German adult crime victims were investigated. By means of structural equation multi-sample analysis, the two groups were compared. Results: The two patterns of prediction for PTSD differed between the countries on important aspects, i.e., in the German sample both value types were predictive whereas in the Chinese sample only traditional values were predictive of PTSD. Traditional values inhibited social acknowledgment as a victim in China and Germany, whereas in the latter sample, these values were related to increased PTSD severity. Modern values predicted social acknowledgment as a victim as well as recovery in Germany, but not in China. Thus, the study of PTSD may serve as a sample case for the cultural co-construction of mental disorders.

The Debate on PTSD as a Universal Valid Diagnosis Versus a Culture-Bound ‘Western’ Construct

Respondents in a variety of countries appear to easily recognize PTSD symptoms without any notion of words such as trauma, stress or PTSD. Despite these and neurobiological arguments in favour of a universal PTSD experience, Kendell and Jablensky (2003) have convincingly argued that validity does not mean uniformity across the globe. Although scholars do find PTSD in many different cultures, the conclusion that PTSD is similar in all cultures is premature, since studies generally do not look for differences that might have yielded so-far unknown (sub)types or variations of the disorder. Future interdisciplinary studies should enable the field to parse out the unique and interactive contributions of biology and culture to the PTSD ‘syndrome’ to increase our understanding how PTSD, posttraumatic idioms of distress, or traumatic personality development are modified by cultural beliefs, meaning systems and cognitive schemata. This lecture argues that such an enterprise would yield a neurobiological and universal core at the biological end of a continuum, with a large variety of culturally induced phenomena at the socio-psychological end of the continuum.

The Clinical Effectiveness of Empirically-Supported Treatments for PTSD

(Abstract #195957)

Symposium/Panel (Clin Res, Practice) Salon 1, 3rd Floor

Kehle, Shannon M., PhD¹; Polusny, Melissa A., PhD²; Chard, Kathleen M., PhD³; Lewis, Jennifer, PhD⁴; Caldwell, Nicola, PhD⁴; Galovski, Tara E., PhD⁵; Blain, Leah, BA⁶; Schnurr, Paula P., PhD⁷; Hembree, Elizabeth A., PhD⁸; Cohen, Sara, BA⁹; Foa, Edna, PhD⁹; Wilt, Timothy, MD, MPH¹, Murdoch, Maureen, MD¹, Hodges, James, PhD¹, MacDonald, Roderick, MS¹

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Several treatments for PTSD have been systematically researched and found to be efficacious. However, there has been relatively little research conducted regarding the clinical effectiveness, or generalizability, of empirically-supported treatments (ESTs). The objective of this symposium is to disseminate data regarding the performance of ESTs for PTSD in clinically-representative settings.

The Effectiveness of Cognitive Processing Therapy in Multiple Settings

Cognitive processing therapy (CPT) has been shown to be effective in treating PTSD due to interpersonal violence in several treatment outcome studies. In addition, one randomized, controlled study has provided support for using CPT with veterans.

This Presentation will attempt to further the research by providing data on the use of CPT as part of an efficacy based outpatient PTSD program housed in a VA Medical center. All clinicians (Psychiatrists, Psychologists, Social Workers, and Nurse Practitioners) were trained in using CPT for PTSD related to both combat and interpersonal traumas. Veterans were seen for an average of 14 sessions of individual therapy. All veterans were assessed at pre-treatment and post-treatment with the CAPS, SCID I and II, in addition to the BDI, Trauma Related Guilt Inventory, Coping Strategies Inventory, STAI, STAXI and various positive mental health measures. Data on 40 males and females will be presented, with the expectation that more data will be collected over time. Initial findings suggest that CPT can be an effective treatment when used in an outpatient PTSD program for reducing primary and secondary symptoms. Problems and pitfalls to implementing an efficacy based clinic model will be discussed.

Establishing the Effectiveness of Cognitive Processing Therapy (CPT)

Previous research has established CPT as an empirically-supported treatment. The methodology of previous CPT trials appropriately protected against threats to internal validity in an effort to establish efficacy through the use of highly trained therapists, a fixed number of sessions, and the lack of manual flexibility. Now that internal validity has been established for CPT, this current NIMH-funded study strives to establish effectiveness by more closely mimicking the population and therapists found in community practice. Manual flexibility has been enhanced and length of therapy varied depending on clinical indications. Outcome and therapy termination is based on functional improvement and good end state, as well as diagnostic status. This study seeks to compare a

symptom monitoring, delayed control to the modified CPT. Upon conclusion of the control condition, subjects are crossed over to CPT. Outcome and process is primarily measured by symptom monitoring diaries, weekly BDI-II and PDS, and the CAPS. Twenty subjects are currently enrolled in the trial with 5 completions thus far. Twenty more will enter the trial before November with an anticipated 15 more completions. Analyses will assess the status of participant improvement as well as direct comparison to previous research in an effort to test CPT's effectiveness.

A Systematic Review of the Effectiveness of Exposure-Based Treatments for PTSD

A recent Institute of Medicine review of treatments for PTSD suggested that exposure-based psychotherapies (EBTs) were the only treatments with sufficient empirical support. However, given the limited data regarding the generalizability of EBTs across patient groups, settings, and providers, the report recommended that future research focus on the generalizability, or clinical effectiveness, of EBTs. The goal of the current project is to examine the generalizability of EBTs by analyzing the effect of patient, setting, and provider characteristics on outcomes. This will be accomplished through a quantitative systematic review utilizing published randomized control trials that examined the efficacy of EBTs. In order to examine the clinical effectiveness of the psychotherapies, eligible studies will be coded along dimensions of clinical effectiveness, with particular attention paid to patient (e.g. race, gender, veteran status, trauma type, disability status), setting (e.g. university hospital, community clinic, VA hospital), and provider (e.g. level of training and supervision) characteristics. Meta-analytic techniques will be used to examine the impact of the clinical effectiveness variables on clinician-rated PTSD, self-reported PTSD, and comorbid symptomology. We will discuss gaps in the evidence and make recommendations for future research to close those gaps.

Impact of Random Assignment to Treatment Condition on Expectancy of Outcome and Treatment Retention

We will describe a study of the dissemination of prolonged exposure (PE) at two community-based clinics. Clients were women survivors of sexual assault or childhood sexual abuse with chronic PTSD. Clients at each clinic were randomized to either PE or "treatment as usual" (either group therapy or individual supportive counseling). Treatment preference was assessed at the pre-treatment evaluation after the client heard about and read a brief description of each treatment. Clients understood that their preference would not influence the treatment condition subsequently assigned. Clients completed a treatment outcome expectancy measure in the first session, after learning of their treatment assignment and hearing a rationale for this treatment. The data on treatment preference, treatment expectancy, and dropout from treatment will be used to address several questions: Do clients who do not receive their preferred treatment drop out at a higher rate? Is there differential dropout rate in PE versus treatment as usual, and is this relationship affected by clients' preferred treatment? Does a match between clients' preferences and the assigned treatment affect clients' expectancy of outcome? Is there a relationship between matching clients' treatment preference and expectancy of outcome that affects dropout? The contribution of these factors to client dropout will be discussed.

PTSD and Intimate Partner Relationships: Correlates and Clinical Implications

(Abstract #196025)

Symposium/Panel (Practice, Clin Res)

Salons 7-9, 3rd Floor

Schumm, Jeremiah, PhD¹; Taft, Casey, PhD²; Meis, Laura, MA³; Sautter, Frederic, PhD⁴; Keane, Terence, PhD⁵; O'Farrell, Timothy, PhD¹; Murphy, Marie, PhD¹; Weatherill, Robin, PhD²; Woodward, Halley, BA²; Pinto, Lavinia, MA²; Watkins, Laura, BS²; Miller, Mark, PhD²; Dekel, Rachel, PhD²; Murphy, Christopher, PhD⁶; Semiati, Joshua, MA⁴; Norwood, Amber, BA⁴; Glinn, Shirley, PhD⁷

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This symposium will explore the association between PTSD and various aspects of relationship functioning. Data will be presented from samples of: male combat veterans from a VA PTSD clinic, women seeking substance abuse treatment, men in a civilian domestic abuser program, and OEF/OIF veterans with PTSD.

Intimate Partner and General Aggression Perpetration Among Veterans in a PTSD Clinic

Increasing attention has focused on aggression perpetrated by combat veterans, although the literature is characterized by a lack of standardized measures, a focus on physical aggression only, and a lack of investigations into both intimate partner and general aggression. We examined rates of intimate partner and general physical and psychological aggression perpetration among a sample of 236 male combat veterans seeking PTSD evaluations in a VA clinic, and correlates of these outcomes. Analyses were conducted separately for veterans with and without partners. Approximately 33% of partnered veterans reported intimate partner physical aggression in the previous year, and 91% reported partner psychological aggression. Rates for general physical and psychological aggression perpetration for partnered veterans were 32% and 81%, respectively. For non-partnered veterans, physical and psychological general aggression rates were 39% and 87%, respectively. PTSD and depressive symptoms were associated with various forms of aggression. Associations between combat exposure and aggression were weak. PTSD symptoms reflecting arousal and lack of control was the strongest bivariate and unique predictor of aggression, with some exceptions. The high obtained aggression rates indicate a need for more careful aggression screening and intervention development for the population of interest.

PTSD Symptoms, Substance Abuse, and Partner Violence Among Female Substance Abusers

Studies show a clear link between substance abuse and intimate partner violence (IPV), and women in substance abuse treatment show high rates of IPV and PTSD. While it is apparent that IPV victimization can lead to PTSD, recent data from male veterans suggests that PTSD may also increase IPV perpetration. This study examines the relationships among PTSD, substance abuse, and IPV victimization and perpetration among women seeking substance abuse treatment. Women who were married or cohabitating with a male partner (N = 279) were recruited from a large civilian substance abuse treatment hospital. Participants were assessed at the beginning of their treatment and then followed every 6 months for 18 months. Prevalence of IPV victimization and perpetration exceeded 50%. Structural equation

modeling (SEM) provided mixed support for IPV in predicting PTSD. SEM supported independent roles of female PTSD symptoms and female and male partner substance abuse in predicting IPV perpetration and victimization. PTSD hyperarousal symptoms were shown to be especially important in predicting IPV. Results suggest a need for more research on PTSD and IPV among women substance abusers. These findings suggest a strong need for interventions that integrate PTSD and substance abuse treatment while targeting reductions in IPV.

Traumatic Experiences and Symptoms of PTSD in a Clinical Sample of Intimate Partner Violent Men

Studies have documented high rates of witnessed and experienced childhood abuse among partner violent men. However, little research has examined exposure to other trauma or PTSD symptoms in this population. The current study examined trauma exposure and PTSD symptoms among 128 men seeking treatment for partner abuse perpetration, 81 of whom had collateral partner data. Eighty percent of participants endorsed at least one traumatic event, and the average PCL-C in the sample was 29 (SD = 17). Nine percent of cases (n = 11) met the cutoff of 50 used to indicate a probable PTSD diagnosis. Trauma exposure was associated with psychological abuse perpetration and general violence after controlling for child abuse and witnessing of interparental violence. PTSD symptoms were associated with relationship problems, psychological abuse, binge drinking, and partner violence perpetration after controlling for substance use problems and childhood exposure to family violence. After controlling for relationship problems, associations between PTSD symptoms and physical abuse were no longer significant. Results suggest that traumatic exposure and PTSD symptoms may have unique associations with IPV perpetrators' interpersonal and relational problems, beyond the effects of family of origin abuse and violence. They also highlight the role of substance use and relationship problems.

The Development of a Couple-Based Intervention to Improve the Management of Anxiety and Emotion in OEF/OIF Veterans With PTSD and Their Spouses

This presentation reports findings regarding the development of a novel couple-based treatment, named Strategic Approach Therapy (SAT), to improve the management of emotions and anxiety in veterans with PTSD and their spouses. SAT employs dyadic stress inoculation procedures, communication training, and problem-solving to teach couples to develop relational skills that allow them to manage the anxiety and difficult emotions that often devastate the relationships of people with PTSD. This manualized intervention consist of 10 sessions and is provided to groups of 2-3 couples by two therapists. Data will be presented from a small sample of six Vietnam veterans and their spouses showing statistically significant reductions in self-reported, clinician-rated, and partner-rated effortful avoidance, emotional numbing, and overall PTSD severity. Findings from an ongoing study using the SAT program intervention with OEF/OIF veterans and their spouses will also be presented. Data suggest that SAT offers promise as an effective treatment for PTSD in OEF/OIF veterans and that it may be used to encourage OEF/OIF veterans to become engaged in other PTSD treatments.

Spreading Best Practices to Communities: Results From Two Statewide Implementations of TF-CBT

(Abstract #196078)

Symposium/Panel (Clin Res, Commun) Salon 3, 3rd Floor

Lang, Jason, PhD¹; Fitzgerald, Monica, PhD²; Franks, Robert, PhD³; Hanson, Rochelle, PhD⁴; Saunders, Benjamin, PhD⁵; Ralston, Elizabeth, PhD⁶; Sawyer, Genelle, PhD⁶; Markiewicz, Jan, MED⁶

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Past efforts to disseminate evidence-based practices to community settings have shown limited success. The Learning Collaborative is a quality improvement model designed to spread best practices through system-wide organizational change. We will describe and present initial results from two statewide efforts to disseminate TF-CBT using the Learning Collaborative methodology.

The Connecticut TF-CBT Learning Collaborative

Initial findings from a statewide effort to disseminate Trauma Focused Cognitive-Behavioral Therapy (TF-CBT) to outpatient clinics across Connecticut using the Learning Collaborative methodology will be presented. The Connecticut Center for Effective Practice (CCEP), a unique partnership between state agencies, academic institutions and an independent policy and research institute, is serving as the TF-CBT Coordinating Center. This initiative will be placed in context with a brief history of the state's efforts to implement other EBPs and to develop a trauma informed system of care. Connecticut's adaptations to the Learning Collaborative model will be described, including funding mechanisms, extensive training on assessment and using measures, online data management, training of referrers, and the inclusion of caregiver advocates at all sites. Agency staff at up to 18 clinics over three years are participating. We will present aggregate Learning Collaborative outcome data using measures at the agency (organizational readiness), therapist (caseload, supervision, fidelity, EBP attitudes) and client (symptom) levels. Agency and clinician predictors of improved outcomes will be presented. The implications and challenges of disseminating EBPs on a statewide level will be discussed.

Project BEST

Project BEST (Bringing Evidence Supported Treatments to South Carolina) is in the first 3-year phase of a 10-year collaborative project to deploy evidence-supported treatments (EST) throughout South Carolina to improve access to high quality mental health services for traumatized youth and their caregivers. The aim of Phase 1 is to test the Community-Based Learning Collaborative (CBLC) approach to training, implementation, and sustained use of TF-CBT in four areas of South Carolina. This initiative involves 42 clinicians from 27 different agencies, as well as 24 "brokers" of mental health services (i.e., those who identify and refer abused children to treatment providers). The CBLC approach includes multiple advanced trainings, action period tasks, ongoing case consultation, and other types of technical assistance. We will present initial findings from Project BEST testing whether specific individual and organizational factors are associated with successful adoption of TF-CBT. These indicators of community 'readiness' include individual therapist factors, such as openness to change and willingness to adopt an EST; baseline competency in TF-CBT; as well as organizational factors such as openness; awareness; and availability of resources. Successful adoption of TF-CBT is measured by clinician-reported use of TF-CBT, broker-reported referrals and engagement in TF-CBT.

Imagery Rehearsal for Nightmares: RCT With Vietnam War Veterans, Pilot With OIF Returnees and Beyond

(Abstract #196108)

Symposium/Panel (Clin Res, Practice) Adams Ballroom, 6th Floor

Cook, Joan, PhD¹; Harb, Gerlinde, PhD²; Ross, Richard, MD, PhD³; Gamble, Geraldine, RN³; Gehrman, Philip, PhD⁴

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Increasing evidence supports a promising cognitive-behavioral therapy, Imagery Rehearsal (IR), for the treatment of posttraumatic nightmares. This symposium will discuss three investigations of IR: a randomized controlled trial (RCT) in Vietnam War veterans, an open trial in Operation Iraqi Freedom (OIF) returnees and the design of a recently funded RCT in OIF and Operation Enduring Freedom veterans.

Imagery Rehearsal: Evidence, Description, and Examples

There is increasing evidence that posttraumatic nightmares respond to an empirically promising cognitive-behavioral therapy called Imagery Rehearsal (IR). In IR, patients choose a repetitive nightmare related to a traumatic event, change it during waking so that it is less distressing, and then mentally rehearse the changed dream script. In addition, IR encompasses psychoeducation regarding Posttraumatic Stress Disorder and nightmares as well as progressive muscle relaxation. This presentation will: (1) briefly review the data supporting the use of IR, including previous studies and RCTs in different populations; (2) describe treatment techniques used in IR, including suggestions for and examples of changing nightmares (such as alternate endings, insertion of reminders into a dream that prompt different ways of viewing it, and distancing techniques); and (3) briefly discuss the content of nightmares and the rescripting of nightmares in our Vietnam War veterans sample.

Imagery Rehearsal for Posttraumatic Nightmares in Vietnam War Veterans: A Randomized Controlled Trial

This presentation will describe the primary findings from a randomized controlled trial of Imagery Rehearsal versus Sleep and Nightmare Management, a psychotherapy comparison condition, in Vietnam War veterans with combat-related PTSD and nightmares. One hundred and twenty-four veterans were randomized to treatment. Intention-to-treat and completer analyses will be presented for the primary outcomes, nightmare frequency and sleep quality, as well as for secondary outcomes, psychosocial impairment attributed to nightmares, PTSD and depressive symptoms. There were no baseline differences between treatment groups on any outcome measure. There were significant differences between treatment groups in regards to dropout, which will be presented and discussed. Mixed effects models will be used to analyze the effects of treatment across time while accounting for baseline covariates and clustering within therapy groups. Interpretation of these results in the context of current evidence as well as generalizability to other traumatized groups will be discussed.

Open Pilot Study of Imagery Rehearsal with OIF Returnees and Design of Bi-Site RCT in OEF/OIF Veterans

The purpose of this presentation is: (1) to report on pilot data obtained in an open trial of IR in OIF veterans, and (2) to present the design of a recently funded Department of Defense bi-site RCT in OEF/OIF veterans. A pilot study of a treatment that combined IR with elements of standard cognitive-behavioral treatment (CBT) for insomnia was conducted in a small sample of OIF veterans. Results

are promising, both with regard to feasibility and efficacy. Pre-post analyses indicated improvement in both nightmare frequency (4; $t=0.95$, $d=0.47$) and global sleep quality (5; $t=1.61$, $d=0.56$), with a small decrease in overall PTSD symptomatology (6; $t=1.62$, $d=0.29$). The combination treatment appears to allow OIF returnees to engage in problem-solving of practical changes in sleep habits while beginning the more challenging work of ameliorating posttraumatic nightmares. The design of a recently funded RCT of IR for OEF/OIF returnees will also be presented. This investigation is a bi-site RCT (Philadelphia VA Medical Center/University of Pennsylvania and National Center for PTSD/Yale University). In addition, the study will also investigate neuropsychological variables important in this population of veterans as well as a possible biological marker of the PTSD-related sleep disturbance.

Mental Health Lessons Learned From the American Red Cross Response to the World Trade Center Attack

(Abstract #196063)

Symposium/Panel (Disaster, Prev El)

Wabash Room, 3rd Floor

Tramontin, Mary, PsyD¹; Halpern, James, PhD²; Ryan, Diane, LCSW³; Avila, Luis, BA⁴; White-Tapp, Maggie, LCSW⁵

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Mental health lessons learned concerning aspects of the three broad stages of a terrorist attack---preimpact (preparedness, planning, warning, threat), impact (inventory, rescue) and postimpact (reconstruction, recovery)---are discussed by key American Red Cross personnel involved on 9/11. The management and mitigation of terrorism engendered traumatic stress are highlighted.

Introduction to Humanitarian Relief Work

For more than 120 years, volunteers and employees of the American Red Cross have assisted those overwhelmed by the needs created by disasters. Assistance has been as simple as a warm plate of food, or as complex as a team of licensed mental health professionals responding to family members after an airline disaster. Nationally, The American Red Cross responds to more than 70,000 disasters yearly, from single-family fires to wildfires to hurricanes to terrorist attacks. We are the premier organization providing humanitarian relief during critical times. A defining moment for this country, and this organization, were the attacks on September 11th. Our New York City based response to the World Trade Center Attacks stressed every element of our team; the enduring commitment and professionalism of our volunteers and staff to assist those in need kept us moving forward with our mission. This presentation will provide information on the evolution of mental health services into the work of the American Red Cross in Greater New York and illustrate how mental health workers and Red Cross responders worked together during the response to the WTC attacks.

Initial Impact

Issues of physical safety for all disaster mental health workers and how to best deploy them are crucial during the impact phase of a disaster. This is discussed from the perspective of the American Red Cross response to the World Trade Center attack. In the aftermath of 9/11, members of the mental health community in New York City were also traumatized, thus blurring the boundary between helpers and victims. Counselors who are directly or indirectly impacted by terrorist attacks may be deeply affected themselves or even impaired to function in their roles. Such

impairment needs to be planned for, assessed and mitigated. Another key aspect of the impact phase that will be featured is that beginning on the evening of 9/11 the major point of contact between survivors and counselors was over the phone via the Missing Persons Hotline. Family member and friends of those missing, neighborhood residents who could not return to their homes or find pets made tens of thousands of calls. Lessons learned concerning effective phone crisis counseling during the impact stage are discussed.

Disaster Mental Health Interventions September 2001 Through June 2002

Commencing on September 11th, 2001, the Greater New York Chapter of the American Red Cross deployed disaster mental health workers who provided an array of services until the WTC site was officially closed in June of 2002. The range of intervention sites will be outlined along with the underlying rationale for such services and the types of psychological support offered. Locations discussed include family assistance centers, respite areas for recovery workers, impacted resident outreach, Ground Zero, memorials, morgue support and the "last load" ceremony. Unique aspects of the application of mental health interventions during a disaster recovery project of very large scope, intensity, and duration will be highlighted. Specifically, the role of close, organized partnerships with non mental health service providers such as chaplains will be explicated. Finally, methods of practitioner self care employed during this time period, including the use of debriefings, will be reviewed.

Putting 9/11 into Perspective-What is Different Now?

This piece of our presentation will outline the organizational lessons learned following the attack on the World Trade Center, how that response has shaped planning for future events and changes in the role of disaster mental health workers at the American Red Cross in Greater New York since 9/11/01. Concepts such as the importance of pre-incident interdisciplinary relationships in planning and preparedness activities, strategies for building a large and well trained core of mental health workers for future need, developing a management plan for spontaneous volunteers and systems for screening and supporting workers during a prolonged mass casualty event will be discussed. Historically, Red Cross chapters that are affected by a mass casualty event experience the loss of significant numbers of staff members and volunteers who leave the field of disaster intervention. Thoughts on why humanitarian responders at the American Red Cross in Greater New York continue to be active in the field despite being affected by the World Trade Center attack will be shared.

A Case Study Using the Trauma Assessment Pathway (TAP) Model

(Abstract #196340)

Workshop/Case Presentation (Practice, Child)

Salon 2, 3rd Floor

Killen-Harvey, AI, LCSW¹; Conradi, Lisa, PsyD²

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²Chadwick Center for Children and Families, San Diego, California, USA

This highly experiential workshop will discuss, "Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model (TAP)." TAP is an assessment-based treatment model developed by the Chadwick Center at Rady Children's Hospital, San Diego, and has demonstrated effectiveness in clinic-based settings for treating children and adolescents between two and 18 years of age who experienced any type of trauma. TAP incorporates assessment, triage, and evidence-supported components of trauma treatment into clinical pathways and includes a Treatment model that focuses on addressing the needs of complexly traumatized children via a Trauma Wheel. Following a brief discussion that will provide necessary background

information for designing and making decisions within an assessment-based treatment protocol, the presenters will prepare a case study of a complexly traumatized child who received therapy using the Treatment component of TAP Model. The components of the Trauma Wheel will be discussed as they apply to this case and audience participation will be highly encouraged. An algorithm discussing how to use the essential components of trauma treatment in this and other cases will be presented along with a discussion of how the TAP model can be adapted for various cultural populations.

Assessing and Enhancing Treatment Engagement in OEF/OIF Veterans

(Abstract #196445)

Workshop/Case Presentation (Mil Emer, Practice) Salons 4-6, 3rd Floor

Murphy, Ronald, PhD¹; Stanton, Theresa, BA¹

¹Psychology, Francis Marion University, Florence, South Carolina, USA

Research shows that many Iraq and Afghanistan veterans who need help for post-deployment problems such as PTSD are not seeking help. Unfortunately, treatment engagement issues in PTSD have rarely been addressed either by researchers or clinicians in the field. The first goal of the workshop is to teach participants how to assess barriers to treatment engagement among veterans, including problem acknowledgement, therapeutic alliance, expectancies and fears about PTSD treatment, stigma and other cognitive/attitudinal barriers, and perceptions of treatment credibility and relevance. The second goal of the workshop is to provide practical and clear strategies for increasing problem acknowledgement, fostering strong therapeutic alliance, and modifying irrational or inaccurate beliefs related to treatment. Specific techniques include methods of strengthening and repairing ruptures in therapeutic alliance in PTSD treatment, activities from the PTSD Motivation Enhancement Group that increase problem acknowledgement and reduce externalizing/blaming attributions, ways of avoiding common therapeutic pitfalls with newly-returned veterans early in treatment, and ambivalence reduction strategies. Participants will be encouraged to engage in behavioral rehearsal and to discuss treatment engagement issues arising in their own work.

Concurrent Session 5

Friday, November 14

8:00 a.m. – 9:15 a.m.

DSM-V

Introduction to the Anxiety Disorders *DSM-V* Process

An Update on the *DSM-V* Development Process

(Abstract #196612)

DSM-V (Asses Dx, Practice) Grand Ballroom, 4th Floor

Phillips, Katharine A., MD¹; Friedman, Matthew, MD, PhD²

¹Professor of Psychiatry and Human Behavior, The Warren Alpert Medical School of Brown University, Providence, Rhode Island, USA

²National Center for PTSD, White River Junction, Vermont, USA

The development of *DSM-V* is under way. This presentation will discuss important groundwork that has been laid for the development of *DSM-V*, including white papers that have been published (“A Research Agenda for *DSM-V*”) and *DSM-V* research planning conferences that have been held in recent years. The current status of the *DSM-V* development process will be described. In addition, some of the key considerations that are guiding the development of *DSM-V* – such as attention to gender and cross-cultural issues, developmental considerations, and the psychiatric/general medical interface – will be discussed. Where does PTSD fit in the overall classification system?

Where Does PTSD Fit in the Overall Classification System?

Should PTSD Continue to be Classified as an Anxiety Disorder?

(Abstract #198262)

DSM-V (Asses Dx, Res Meth) Grand Ballroom, 4th Floor

Resick, Patricia, PhD¹

¹National Center for PTSD/Boston VA Healthcare System, Boston, Massachusetts, USA

Posttraumatic stress disorder has been classified as an anxiety disorder since its inception in 1980. On one hand, this classification is logical because of the level of fear that often accompanies traumatic events, the conditioning that appears to occur with previously neutral cues, and the influence of avoidance on the maintenance of the disorder. On the other hand, there is also evidence that fear may not be the best predictor of who does or does recover from traumatic events such that a diagnosis of PTSD is warranted, and does not capture the array of other emotions such as anger, shame, sadness, or grief that may also accompany the disorder or even predominate in many cases. This talk will describe where PTSD falls with recent efforts to factor analyze Axis I diagnoses and will review studies that attempt to predict who will develop PTSD following trauma, to examine the question of whether PTSD is truly an anxiety disorder or should be classified elsewhere.

Is PTSD a Stress Induced Fear Circuitry Disorder?

(Abstract #197880)

DSM-V (Bio Med, Asses Dx) Grand Ballroom, 4th Floor

Shin, Lisa, PhD¹

¹Department of Psychology, Tufts University, Medford, Massachusetts, USA

To address the question of whether PTSD is a stress induced fear circuitry disorder, this presentation will summarize recent relevant functional neuroimaging findings in PTSD. Many recent studies