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ISTSS President Eve Carlson, PhD, and Program Chair Debra Kaysen, PhD

President's Column

*Eve Carlson, PhD
President*

By the time you are reading this, the abstract submission process for the 2012 ISTSS Annual Meeting has wrapped up. We hope the submission process was a little better this year. Over the years, continuing education (CE) requirements have been escalating, and the structure of our symposia is more complex than most abstract management software is designed to handle. Our staff, program chairs and the Annual Meeting Committee will continue working to make the abstract submission process as easy as possible to negotiate. This year we were not required to collect CVs from co-authors, so we hope submitting was less burdensome.

Meanwhile, program co-chairs Debra Kaysen and Wietse Tol have been hard at work for months planning the 2012 Annual Meeting in Los Angeles. We are inviting and confirming keynote speakers, Master Clinicians, and—new this year—Master Methodologists to present on topics relating to our meeting theme, “Beyond Boundaries: Innovations to Expand Services and Tailor Traumatic Stress Treatments.”

The meeting will focus on innovative strategies for outreach, assessment, treatment and programs that will enable us to reach more trauma survivors by delivering services in a wider variety of contexts. It will also address innovative conceptualizations in research, measurement and clinical methods, all of which can help us better understand and tailor our services to people with different responses to traumatic stress. We will update information about the program as it takes shape on the [ISTSS website](http://www.istss.org).

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In late May, ISTSS will be one of the sponsors of the 5th World Congress on Traumatic Stress in Mexico City. Visit the website for an [extensive list of meeting speakers](#). The meeting will be held in the Cuauhtémoc District of Mexico City, which is considered the cultural and historic center of the city. While Mexico City may seem a long way away, it is actually closer to both the east and west coast of the U.S. than either are to each other. The ISTSS Board of Directors will hold its semi-annual meeting just before the congress begins, and we will be glad to see you there.

Most of the 30-plus work groups of ISTSS have made initial plans for the year and begun their work. Some groups still need additional members to get their work accomplished, so keep an eye out for ads in *StressPoints* seeking volunteers for various efforts.

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As you may have learned via email notices, webinars have begun for the year. We will be scheduling up to 10 this year, with a future goal of holding webinars monthly. You can visit the ISTSS website to find out about [upcoming webinars](#).

And don't forget to check out our growing list of audio and video [Expert Trainings program](#) – now half price for members and downloadable to mobile devices. I have listened to them all, and know you will find them both educational and engaging. It's just like being there, only you can rewind to listen to complicated parts!



From Our Website: Do You Know?



The website has fact sheets and pamphlets for the general public and for consumers. The publications provide introductions to important trauma-related issues including trauma and relationships, trauma and children, and traumatic grief. Many are available in multiple languages such as Spanish, Chinese and Arabic.

Visit the ISTSS website to see our [public education materials](#).

Convergent Approaches to Understanding the Neurobiology of Fear and PTSD

Kerry J. Ressler, MD, PhD
Emory University
Howard Hughes Medical Institute



It is with great honor that I accepted the 2012 Robert S. Laufer, PhD, Memorial Award for Outstanding Scientific Achievement. I believe that this award represents the increasing recognition of the importance of examining, through translational research, the neurobiological mechanisms of fear and how this informs our understanding of trauma- and fear-related disorders. For it is only through a greater understanding of the neural mechanisms of the effects of trauma on the brain will we be able to develop rationally designed therapeutic approaches and interventions.

An advantage that the trauma-related disorders share, arguably to a greater extent than any other psychiatric malady, is the wealth of knowledge that has been deduced over decades in the understanding of the neural circuits mediating fear processing. This work has demonstrated that brain regions involved in emotion regulation, including the amygdala, hippocampus and prefrontal cortex areas, are highly conserved across mammalian species. Thus the functional dissection of the 'fear reflex', its hardwired amygdala outputs regulating the stress, fight-or-flight, and other responses, as well as its modulation by cortical and hippocampal areas, have demonstrated an enormous level of conservation across organisms.

Repeated observations with neuroimaging approaches in humans have now also shown that these same regions are involved at both a functional and structural level in the expression of fear and in the pathological responses to traumatic memories. The further functional dissection of these emotion and fear

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processing circuits in animal models will continue to lead to an advanced understanding of the underlying neural circuitry.

The rapidly advancing field of genetics research is also providing new ways of understanding potential differences between those who recover versus those who don't, and are at risk for posttraumatic stress disorder (PTSD) following trauma exposure. Large scale genome-wide association studies are now underway in both traumatized civilian and military populations. In addition to examining individual single nucleotide polymorphisms that differentially associate with PTSD risk, new techniques are allowing examination of copy number variants, rare variants, and even complete genome sequencing.

Besides these approaches, examination of 'non-classic' ways of gene regulation, including epigenetic and microRNA modulation, are being brought to bear in understanding differential gene transcriptional control. Understanding genetic pathways is useful on the one hand, for prediction of who is at risk for PTSD following a trauma. Additionally, one could argue that a potentially even more important outcome is that these pathways point to the underlying biology, which provides new targets for therapeutic treatment and prevention approaches.

Perhaps the most exciting new approaches spanning human and animal neurobiology research on fear and trauma will be the intersection of genetics and neuroimaging. As gene pathways are prioritized across these studies, the wealth of understanding regarding the neural circuits of fear provide optimal, known targets in rodent models for understanding gene function at a mechanistic level. Genetic markers of risk and resilience, when combined with differential brain activation tasks or functional connectivity tasks, have the potential to help define important intermediate phenotypes – the brain mechanisms underlying the complex clusters of symptoms we label as disorder.

I believe that it is an extraordinarily exciting and hopeful time for our field. The convergence of neuroimaging and genetic approaches with large, well-powered populations of traumatized subjects is intersecting with the neuroscience of fear biology, among the best understood circuits in the brain underlying complex behavior. This intersection makes it possible that the disorders of fear-regulation, including PTSD, could be among the first psychiatric disorders to be understood from a truly mechanistic perspective.

More importantly, it may mean that within our collective grasp are future approaches, based on rational design from a deeper scientific understanding, for new treatment, intervention and prevention approaches to improve suffering in our patients' lives.



Interested in getting more involved with ISTSS but worried about time constraints?

We have the perfect activity for you! ISTSS is looking for volunteers to help with an ongoing project of transforming pre-meeting institutes and workshops from our annual meetings into online continuing education programs. You can help ISTSS while you learn and earn a program (with or without CE credits) in compensation. The work involves spending 6-10 hours listening to a program, viewing the slides and writing the continuing education items over a 3-4 week period. This is a great way to join in the "behind the scenes" work at ISTSS.

For more information, contact:
Sara Aboul-Hosn, Online Expert Training Development Coordinator
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About a Life of a Fellow ISTSS Member

Charles R. Figley, PhD
Tulane University

Dr. David Cabrera, a fellow ISTSS member, died in combat in Afghanistan, on October 29, 2011. Patricia K. Kerig, the editor of *StressPoints*, urged me to share my thoughts about Dave. His official obituary is included in this issue as well. This tribute is in addition to the memorial service held at the 2011 ISTSS Annual Meeting, the first of its kind, for Dave and other ISTSS members who had died recently. We hope to continue that tradition at the 2012 meeting in Los Angeles.



As his official obituary states, Dave was in the prime of his life when he died. He was a devoted father, skilled social work practitioner and expert on military mental health. This is a recent photo of Dave. It was taken at his informal “pinning ceremony” at his home in Maryland with his family and many, many friends.

I got to know Dave in 2008 when I served as a consultant and educator for the U.S. Army in Europe responsible for the mental health needs of soldiers and their families, most of whom had experienced multiple deployments.

Over a beer in Heidelberg, we designed a study of combat medics that was later funded. He was scheduled to co-present with me at last year’s ISTSS conference in Baltimore, but was deployed to Afghanistan a month earlier. He had just been promoted to the rank of Lieutenant Colonel, one of the highest ranks for social work practitioners in the military. We had been to each other’s homes numerous times and were part of each other’s families.

I learned of his death on October 30, the weekend before the ISTSS meeting. I must admit that his death has hit me hard. I believed that I was well-prepared to manage trauma and death. I was not.

I tried to carry on as best I could. At the conference I struggled to get through my responsibilities including the presentation of our paper Thursday morning. I attended his personal funeral, with many friends and family, in his church near his home in Maryland and then the official military funeral in the Houston, Texas area, and learned more about his life and how much he was loved and admired.

As you read through his obituary, imagine the loss to his family and particularly his wife, August. She and I are committed to making sure you, and as many as possible, know about Dave’s life and his contributions as a scholar. The three-year study of combat medics and the many publications that emerge from it include his name as co-author.

Consistent with his predictions, we are finding that this group of soldiers is a special group who, for the most part, joined the Army to save lives, not take them. But, as with all wars, they ended up contributing to both. Their post-war psychosocial reactions demonstrate the challenges of that reality.

Dave lived his life to the fullest and provides an extraordinary role model to all of us of being as both a caring and loving person while serving soldiers in war and peacetime. We both hated war but admired those who served their country in spite of it. God bless you, Dave Cabrera.

Following is an approved version of Dave’s obituary:

Life of Fellow ISTSS Member continued from page 4

Lieutenant Colonel David E. Cabrera, MSW, PhD
Medical Service Corps, United States Army

Army Lt. Col. (Dr.) David E. Cabrera, a licensed clinical social worker and assistant professor of family medicine at the Uniformed Services University of the Health Sciences (USU), was killed in action in Afghanistan on October 29, 2011.

Dr. Cabrera was born in Boynton Beach, Florida, and later moved to Houston, Texas, where he graduated from Sam Houston High School in 1988. He earned his undergraduate degree in psychology in 1992 from Texas A&M University in College Station, and was a lifelong Aggie fan. He earned a Master of Science degree in social work from the University of Texas, Arlington, and in 2006, he completed his doctorate degree in social work at the Catholic University of America, in Washington, D.C.

He joined the U.S. Army in January 1996 as a Medical Service Corps officer. After his initial training, he was immediately deployed in support of Operation Joint Endeavor/Joint Guard (Hungary, Croatia and Bosnia). He spent more than 15 years on active duty, with assignments in Wurzburg and Heidelberg, Germany; Walter Reed Army Medical Center, Washington, D.C.; and twice at Fort Lewis, Washington, where his latter assignment was as the Brigade Behavioral Health Officer for the 3/2 Stryker Brigade Combat Team, managing the behavioral health and combat operational stress programs for more than 4,500 soldiers in six battalions and five separate companies.

In June 2006, he was deployed with the 3/2 Stryker Brigade to northern Iraq for five months. In February, 2010, he joined the faculty of the Uniformed Services University (USU) in Bethesda, Maryland, the nation's only federal health sciences university, as the director of social work. He held an appointment as assistant professor in the USU Department of Family Medicine, where he saw patients, taught third- and fourth-year military medical students, conducted research in the fields of resilience, PTSD and post-traumatic growth and avidly participated in a number of university field training exercises and activities.

He was promoted to Lieutenant Colonel on September 1, 2011, in a small ceremony at USU, surrounded by his family, friends and close colleagues. He left the U.S. for deployment to Afghanistan on September 30. Just less than one month in-theater, he was killed in action on October 29 in Kabul as a result of a suicide bomb attack on the NATO convoy with which he was riding.

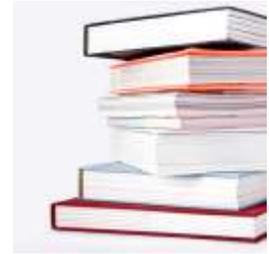
Dr. Cabrera's humor, easy-going nature and infectious smile made him popular with family, friends, colleagues, medical students and patients alike. His dedication to the troops he served throughout his career was evident in his caring and compassionate approach to his work. Dr. Cabrera's research interests also conveyed his commitment to improving the lives of service members, veterans and their families. He was an unstoppable adventurer who traveled the world with his family and friends, climbing Mt. Kilimanjaro, Mt. Rainier and other mountain peaks. However, it was the ocean to which he was most drawn, and his love of the sea was evident to all who knew him.

He was a truly loving and devoted husband and father, and is survived by his wife, August Cabrera, and sons Maxwell and Roanin Cabrera, of Maryland, son Corbin and daughter Gillian Cabrera, of Texas. The social work community extends its condolences to the family of our Brother-in-Arms.

Prof. Charles R. Figley, PhD, the Paul Henry Kurzweg, MD, Distinguished Chair in Disaster Mental Health at Tulane University and Graduate School of Social Work Professor and Associate Dean for Research. Phone: 504-862-3473; Email: Figley@Tulane.edu; Web: www.charlesfigley.com



Trauma and World Literature: *Bastard out of Carolina* By Dorothy Allison



In her acclaimed autobiographical novel *Bastard out of Carolina*, Dorothy Allison portrays the experience of physical, emotional and sexual abuse in a working class family and, [as she has said](#), provides a memorial to her own family.

In the following passage, Bone, a survivor of abuse by her stepfather Glen, has been rescued after a final brutal beating and rape which Bone's mother witnessed but failed to protect her from, instead fleeing with Glen to protect him from prosecution. Bone has just returned from the hospital to the care of her aunt Raylene.

“The dog turned to me with hopeful brown eyes, his tongue hanging down as he wanted me to invite him up on the bed. Big dumb sad eyes waited on me. I wanted to beat my fists until the bones splinted, kick my heels into raw meat, scream until my tongue pulled loose and split at the root, but everything was slow, words and feelings just moved across my brain. I was slow, numb and stupid. The pain in my arm was comforting, the throbbing in my temple was music I needed in order to keep breathing.” (p. 302)

“I looked into the dark night, past Raylene's arm and the porch railing ... I shook my head and swallowed. I knew nothing, understood nothing. Maybe I never would. Who had Mama been, what had she wanted to be or do before I was born? Once I was born, her hopes had turned, and I had climbed up her life like a flower reaching for the sun. Fourteen and terrified, fifteen and a mother, just past twenty-one when she married Glen. Her life had folded into mine. What would I be like when I was fifteen, twenty, thirty? Would I be as strong as she had been, as hungry for love, as desperate, determined, and ashamed?

My eyes were dry, the night a blanket that covered me. I wasn't old. I would be thirteen in a few weeks. I was already who I was going to be ... When Raylene came to me, I let her touch my shoulder, let my head tilt to lean against her, trusting her arm and her love. I was who I was going to be, someone like her, like Mama, a Boatwright woman. I wrapped my fingers in Raylene's and watched the night close in around us.” (p. 309)

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Contribute to *StressPoints* Trauma and World Literature Feature

Passages from literature can capture truths about trauma and its survivors. ISTSS members are invited to share a favorite passage or quote from literature that might not be well known, but which offers insight about the psychological effects of trauma or path of healing.

Send submissions to Howard Lipke and Harold Kudler at HLipke@aol.com.

What are we Teaching Introductory Psychology Students About Trauma?

Kathryn Becker-Blease, PhD
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In university introductory psychology courses, students learn about science that can help people work effectively in groups, raise healthy children, think and learn efficiently, cope with stress, reduce discrimination and so forth. How well do introductory psychology textbooks help students understand traumatic stress? In the past, concerns have been raised about the coverage of trauma, child abuse in particular, in introductory psychology textbooks (e.g. Gleaves, Rucklidge & Follette, 2007; Letourneau & Lewis, 1999).

To illustrate the variability in how introductory psychology textbooks cover trauma, maltreatment, post-traumatic stress disorder (PTSD), dissociative disorders and repressed memory, I searched for information on these topics in four textbooks that have recently been published. My goal was not to compile an exhaustive list of how trauma is covered in these books, or even to review these books. Rather, I present some observations and examples so that: 1) instructors of introductory psychology can better use their textbooks in teaching about traumatic stress; 2) instructors of related courses, like psychology of trauma, can be better informed about their students' prior knowledge; and 3) other interested ISTSS members can gain some awareness into what undergraduate students are being taught about traumatic stress.

Traumatic Stress Studies

One textbook I reviewed provides something approaching an overview of traumatic stress studies. In it the authors provide an explanation of traumatic stress as a concept related to, but distinct from, general stress or mental health. This section is welcome as it helps tie together some general principles about the nature of trauma and reactions to trauma that are otherwise non-existent or scattered throughout a textbook. Some of the information in this particular textbook is misleading, however. In defining "traumatic stressors" this book includes "catastrophic events, such as natural disasters and terrorist attacks." The focus of the section is catastrophes, but it also includes "personal losses" and grief associated with death, a romantic break up and a friend's betrayal. As a result, students are likely to need some help clarifying the distinction between distress and traumatic stress.

Research related to rape—apparently stranger rape—and combat are presented, and one sentence accurately explains gender differences in the kinds of traumatic events people experience. Overall, readers of this section will get some good information about more public, less secretive kind of trauma, such as catastrophes, combat and terrorist attacks, but little to no information about traumatic events in interpersonal contexts such as child abuse, elder abuse, bullying or intimate partner violence.

Child Abuse

Students should, in my opinion, leave an introductory psychology course knowing the pervasiveness of child abuse, the effects of child abuse on developing humans and how to respond to suspected child abuse effectively. Yet, few textbooks cover child abuse in any systematic way. In some cases, this omission may be leaving students with inaccurate information. For example, one textbook describes disorganized attachment as a type of insecure attachment caused by insensitive caregiving. Students in introductory psychology courses should get the message that some kinds of parenting are not just sub-optimal, but abusive, and produce quite serious problems.

Child abuse might also be covered in textbooks under the topic of parenting. However, discussions of parenting typically include a description of Baumrind's parenting styles, but do not address the causes,

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types and consequences of abusive parenting practices. Here is an opportunity to talk about how the samples studied effect the results researchers obtain. Instead, child abuse typically is covered under textbook sections on recovered memory and dissociative disorders.

Dissociative Disorders

Coverage of dissociative disorders varies. Some textbooks cover all dissociative disorders, and others focus only on dissociative identity disorder (DID). One text places dissociative disorders within the personality disorders spectrum rather than with other Axis 1 clinical syndromes. All the textbooks I reviewed indicate that many people diagnosed with dissociative disorders report a history of abuse and all question the veracity of these memories or any causal link to varying extents. All indicate that DID is a diagnosis that is not accepted by all clinicians. For those with expertise in trauma, there is an opportunity here to walk through the logic of the arguments presented.

For example, Krause and Corts (2012) write, “The fact is that most trauma victims remember their experiences (Cahill & McGaugh, 1998), thus, many psychologists find it unlikely that traumatic experiences can directly lead to DID” (p. 491). There is much to unpack here, which could make for a great classroom discussion. What does it mean to “remember” an experience? How can psychologists measure memory for trauma? Does it make sense to conclude that trauma cannot lead to DID because most people recall trauma? Is it that psychologists doubt that trauma *can* lead to DID, or do they doubt that it happens *frequently*?

Posttraumatic Stress Disorder (PTSD)

Coverage of PTSD also varies. One textbook covers PTSD in a section on stress and health and two cover it as an anxiety disorder. In the case of another textbook, I could find no coverage of PTSD. Of those that cover PTSD, one textbook mentions accidents, rape, combat, natural disasters and a mass murder as being associated with PTSD. This book makes no mention of common, but more secretive, events like child abuse, elder abuse, bullying or intimate partner violence.

Another textbook links PTSD explicitly with war, attempted murder, rape, natural disasters, sudden death of a loved one, and physical, sexual abuse and domestic abuse. Thus, when teaching students about trauma, instructors are advised to find out if PTSD is covered in the textbook, and if so, whether the coverage includes a full spectrum of traumatic events. Others who work with clients or public may need to explicitly explain that PTSD is related to many kinds of traumatic experiences.

Memory for Trauma

All the textbooks I reviewed include information about recovered memories for trauma. Half of the books include a statement in this section telling students that child sexual abuse is a real problem. All warn students about the risk of therapists using suggestive techniques to implant false memories. One indicates that students should be more skeptical of recovered memories than continuous memories, while another cites evidence that trauma can affect the way people store memories. Two books frame the “recovered memory debate” as a debate between academic researchers and clinicians.

Overall, the information presented on recovered memory is reasonably accurate, but it is worth reading these sections carefully with the class in order to clear up any inaccuracies. One book stands out for its coverage of societal and perpetrators’ memory for trauma. Gazzinga, Heatherton & Halpern (2013) explain that “Groups’ collective memories can seriously distort the past. Most societies’ official histories tend to downplay their past behaviors that were unsavory, immoral, or even murderous, “perpetrators’ memories are generally shorter than victims” (p. 302).

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In conclusion, among the small sample of new textbooks I reviewed, I found that students learn about trauma mostly in the context of mental health and memory. The accuracy and amount of information varies. Coverage of the causes, prevalence, prevention, and sequelae of secretive kinds of abuse, including child abuse and interpersonal violence, is nearly non-existent. Instructors of introductory psychology courses can help students better understand trauma by clarifying and augmenting textbook information.

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Media Matters – Trauma Literacy for Journalists: The Next Steps

Chiung-wen (Julia) Hsu

2011-2012 Fulbright Scholar, Dart West and Department of Communication, University of Washington, Seattle, Associate Professor, Department of Radio and Television, National Cheng Chi University, Taipei

Over the past decade, efforts by journalists, mental health care professionals and educators have successfully introduced the importance of understanding trauma to many news media workers and journalism students. What will be the next steps? I believe we must implement a three-tier approach by including more trauma literacy education in schools, during job orientations and in ongoing on-the-job training, and we must continue to assess the effectiveness of trauma training on journalists' perceptions and daily practices. Furthermore, curriculum content and pedagogies need further assessment and development, drawing from solid research and hands-on experience.

When it comes to training, journalists are not like first respondents and health care providers facing trauma events and trauma-exposed populations as soon as they engage in this field. In journalism schools, students are not guaranteed to learn trauma literacy and related practices. After graduation, if they are not assigned to cover crime and justice, disaster or combat, they have fewer chances to learn how to cover trauma news well. But any journalist may eventually be faced with covering important breaking news such as man-made or natural disasters, whether or not the news is happening in his/her own beat.

Using materials from the [Dart Centre for Journalism and Trauma](#), I have implemented workshops in Taiwan for local journalists and journalism students. Three months following one workshop, held in an indigenous disaster vulnerable area, participants were interviewed about their experiences. Their responses can help move journalism and trauma training forward.

Most raised the question of appropriate timing for receiving trauma literacy training. They all found that the workshops gave them a chance to better understand victims' and survivors' emotional stress and taught them how to examine their own stress and release it. In addition, those interviewed noted that disaster survivors and crime survivors experience different reactions, and these

differences should be incorporated into training curriculum. Yet, little research has focused on working with survivors of different types of disaster.

Though some newsrooms offer debriefing and counseling for journalists after covering trauma events, many journalists are wary of asking for help. In "macho" journalism culture, counseling implies that the staff members might not be capable of performing as a journalist. Some research finds that training journalists before covering trauma news would help them more than counseling (Green and Sykes, 2005). Thus, I suggest three different times for teaching basic journalism and trauma literacy: during college, as part of career orientation and on-the-job during and after coverage of major traumatic events.

I also encourage solid research on the effectiveness of three techniques to help journalists reporting trauma: training, debriefing and mental health intervention. More quantitative and qualitative information is needed to evaluate the appropriate curriculum, timing and pedagogy of trauma training programs for both journalism students and media workers.

First, we need more research on the effectiveness of existing training to better inform curricula content for different levels and timing of journalism and trauma education. Should journalism and trauma be presented as an introductory course for students, incorporated into an advanced reporting course, or part of an inclusive approach for the entire journalism curriculum? Should content include lessons learned from previous news events, case studies for on-job training, and/or role play scenarios? How can we better draw from psychology to teach journalism students and working journalists about trauma reactions?

Resilience and positive psychology seem to be the crucial theory foundations for training, according to Wessely, Bryant, Greenberg, Earnshaw, Sharpley and Hughes (2008) and Reivich, Seligman and McBride (2011). They claim that the curricula are

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empirically validated in the field of positive psychology work. Furthermore, understanding post-traumatic growth is found to be essential for journalists' trauma alleviation (McMahon & McLellan, 2008).

As for pedagogy, Reivich, Seligman and McBride (2011) discuss the "train the trainer" model used to disseminate their curriculum to the U.S. Army. They trained noncommissioned officers with resilience skills and taught them how to teach those skills to their fellow soldiers.

How about journalists? My research in Taiwan shows that working journalists are eager to have information on real case studies and discussion format instead of standard textbook information and lectures. It is essential to focus on what kinds of pedagogies are suitable for journalism school students, career orientation and on-the-job training. For instance, participants in the Taiwan workshops especially appreciated the detailed trauma scenarios incorporated into the training, similar to their on-the-job experiences. However, we do not know if these specific trauma scenarios and connected moral reasoning are entirely suitable for introductory courses in journalism school.

The assessment of trauma training and education should be multidimensional. Journalists who have received training can be evaluated in terms of job performance, emotional stress, resilience, physical health and other important indexes. Journalists face different types of traumatic events, which might result in diverse emotional and physical health effects. Research has shown that not only the rare extreme disaster but also every day events like car accidents trigger journalists' emotional stress. We need to further explore how media workers are affected by exposure to different types of tragic events, and use this information to inform content and pedagogy of training.

In addition, cultural context of trauma literacy workshops cannot be ignored. In Western culture, journalism trainers have focused on peer meetings and discussion. However, in the Taiwan workshops, journalists have expressed fear of

sharing their feelings with colleagues and peers from other media due to severe competition and more extreme "macho" culture. Mattar (2011) offers recommendations to develop psychology curricula and training based on "cultural competence in the field of psychology."

More research is needed on cultural differences in journalism to better assess appropriate methods of training in different locations and situations.

What else can contribute to the efficacy of trauma literacy workshops? Continued interdisciplinary study of trauma and journalism might uncover the hidden treasure.

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Research Methods – Development and Testing of a Locally-Adapted Psychosocial Assessment Instrument: A Personal Account of Work Along the Thai/Burma Border

Emily E. Haroz, MA

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Any first day of work is hard. A first day that starts after flying 30 hours to Bangkok, arriving at midnight, getting four hours of sleep and taking a “puddle-jumper” to the Thai Burma border town of Mae Sot, is more than hard. When we finally touched down in Mae Sot, I was sleep deprived, slathered in Deet (dengue is rampant in this part of Thailand) and nervous about my first overseas research experience. I was not new to living and working abroad, having traveled extensively, including working in Malawi at an orphan care center and studying abroad in Cuba during college. Still, I was new to the role of applied researcher in a community that I only knew from afar.

Mae Sot, Thailand, is very much a border town. The transient nature of the place is palpable. Although the official bridge across the Irrawaddy between Burma and Thailand was closed when I was there, the informal inner-tube ferries were thriving. People and goods were pouring back and forth between the two countries. I quickly observed that for a Burmese person displaced in Thailand there are many ongoing dangers and high-stakes undertakings involved in being displaced. Often these displaced persons are fleeing ongoing fighting between ethnic groups and governmental forces or risk of detention and/or torture. Many arrive in Thailand to work in low wage factory jobs, or agricultural positions, in which they face police harassment and risk of deportation. Most are undocumented and cannot move about the town freely without fear of being stopped and forced to pay bribes.

In Mae Sot, there are few available mental health services for anyone, let alone the marginalized Burmese community. It is in this context that the research team, comprised of Paul Bolton (Project PI), Courtland Robinson (Site PI), Catherine Lee (Project Coordinator) and myself, was to undertake a scientifically rigorous project aimed at providing comprehensive and effective mental health services for Burmese living in Thailand who had experienced torture by the military regime in Burma or other trauma.

The project involved the design, adaptation and measurement of a randomized clinical trial of a psychological intervention for the study participants. The aspect of this process I will focus on is the adaptation and validation of a measure of post-trauma psychological symptoms. First, it is important to adapt measures to local contexts in order to capture the variation in expressed symptoms among populations other than those in which the measures, or the criteria for the psychological disorders, were developed.

Second, it is extremely important to develop efficient screening measures for low-resource communities in order to deliver interventions appropriate to the local context. Simple translation or back-translation of existing instruments does not fully convey meaning of idiosyncratic expressions and can result in categorical fallacies (Kleinman, 1987), resulting in symptom clusters based on Western domains of disease. Adapting measures to the local context, through utilizing previous qualitative work, enhances the cross-cultural relevance of assessment and may enable clinicians to develop locally-relevant treatment goals.

After months of analyzing previously gathered qualitative data, I was tasked with traveling to the study site with the senior investigators to help carry out the validation phase of our adapted mental health screening

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tool. Prior to arriving we had intensively reviewed Free Listing and Key Informant interviews (both of which are qualitative methods) in order to identify the relevant psychosocial problems in this community and to determine how these problems manifest in people's behavior and words. This analysis enabled us to adapt existing psychological measures to fit the symptoms and syndromes reported among Burmese refugees living in Thailand by using their language when measuring symptoms and adding locally relevant symptoms. The subsequent questionnaire included the adapted measures and visual aids to help in interpretation and comprehension.

In addition to recruiting and training interviewers to administer the questionnaires comprehensively and reliably, our goal was to establish the reliability and validity of the measures in the context of Mae Sot. Reliability is fundamentally the elimination of random error from a measure. Establishing reliability involves repeated administration of a measure to ensure that variation in scores does not have to do with a particular interviewer or with the questions themselves, but best approximates real variation in people. Validity concerns minimizing bias and ensures that a psychological instrument measures what it purports to measure.

Of course, establishing the psychometric properties of scales in complex situations with low resources can be very difficult. One of our chief concerns was establishing criterion validity to aid in the screening process for the larger randomized control trial of the psychotherapy intervention. We had to figure out how to use our questionnaire to determine the level of severity of depression and trauma related symptoms that indicated clinical impairment. Typically a clinician diagnosis is considered to be the "gold standard" for determining criterion validity and a clinical cut-off score for a continuous scale is established by applying Receiver Operating Curve (ROC) analysis. However, in Mae Sot and in many other places, no mental health clinician was available. We had no "gold standard." Thus, we used an alternative method for assessing criterion validity.

The method of criterion validity we utilized involves a validation process among known groups. The basic strategy is for local community members and leaders to list individuals they work with whom they believe have the 'syndrome' in question and then to verify this community-based diagnosis with the individuals themselves. If both the community member/leader and the individual agree, then it is likely that that person does in fact suffer from that "syndrome." Alternatively, if a community member/leader identifies a person as not having that "syndrome" and that person concurs, then it is likely that the person is "syndrome" free. Using these classifications we planned to compare scale scores to these "diagnoses" and determine appropriate cut-off scores to screen people into treatment (for more details on this process see Bolton, 2001).

When I arrived in January, the lists of people who had been categorized were supposed to have been completed and our plan was to do a brief training on administering the questionnaire and then begin interviewing participants from the lists to complete the validity study. However, as in most research projects conducted remotely, upon arrival we found a very different situation. The community leaders had not been able to find many concordant pairs of people who agreed with the leaders' "diagnosis." Moreover, although the depression-like syndrome had a name in Burmese and was recognized in the community, symptoms resulting from past trauma were less recognized or acknowledged. Thus, we initially focused on clarifying the definition of these syndromes and determining alternative ways to obtain concordant pairs.

In the end, we were able to generate a list of over 200 potential respondents. A team of 11 interviewers (all displaced people from Burma) conducted 195 interviews (164 first-round interviews and 31 repeat interviews) over seven days. It was quite an undertaking and quite remarkable to witness the energy and commitment of the interviewers.

However, upon returning to the U.S. and completing the data analysis evaluating the reliability and validity

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of the instrument, we realized that our questionnaire had failed to establish many of the psychometric properties we had hoped it would. Whereas many of our scales showed good reliability (test-retest, inter-rater and internal consistency) and ecological validity, we were unable to establish criterion validity. There was no difference in symptom severity between those who were identified as having the disorder and those identified as disorder-free, and therefore we were unable to identify who was in most need of services. After discussion of the findings with our local partners, a number of possible explanations were suggested:

- problems with understanding the process of generating the known-group validation lists;
- the opinions on which the original lists were wrong; the existence within this population of an endemic low level of symptoms;
- difficulty distinguishing between normal every-day difficulties more clinically relevant problems;
- and, the instrument simply being no good.

Ultimately it was agreed that the instrument was useful, but we would need an alternative method for determining trial eligibility.

For me personally, such a disappointing result for my first major attempt at applied psychological epidemiology was quite a blow. Nonetheless, it provided a remarkable learning experience. Establishing a cut-off score had been imperative to the study as a whole and, when that proved extremely difficult, we had to determine an alternative way for the community mental health workers to use the adapted instruments to establish who was in need of services.

In the end, we identified in the literature several other methods for determining cut-off scores and considered their applicability to this particular setting. These alternatives include using standard cut-off scores that have been tested in similar communities, using an algorithmic-based scoring approach to generate a diagnostic score, and comparison of scale scores with other associated measures (construct validity). The process of selecting an alternative illustrates the complexities that go into measuring mental health across cultures in low-resource settings. Although the field of psychology in general is faced with ongoing measurement issues, these issues become even more challenging in places where resources are scarce and expression of psychological phenomena may be different. Despite these uncertainties, it is no less important to undertake such endeavors and I am committed to continuing to work on these challenging issues to enhance the quality of mental health care across cultures.

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Experiences in International Collaboration: Consensus Conferences on Pediatric Psychological Trauma in Denmark and Norway

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The study of pediatric psychological trauma is still very much in its infancy in Scandinavian countries. However, two recent (January 2012) conferences focused on pediatric psychological trauma were held in Denmark and Norway. Both conferences were the first of their kind and were held to raise awareness and interest in the field of infant psychological trauma, with the ultimate aim of sparking the development of the field in Scandinavia. The planning and execution of these two important events was facilitated by a productive, international collaboration between two nations.

To date, there is a paucity of research concerned with young children's experience of trauma and their corresponding response to trauma. It has been a widespread belief that infants and very young children are not affected by stressful and traumatic experiences to the same degree as older children and adults, given that they are too young to describe and remember these experiences. However, recent research has shown that even very young children are far more affected psychologically by pain and traumatic experiences than previously believed (see www.psykotraume.dk/nyheder). As a result, it is vital that professional personnel (psychologists, psychiatrists, doctors, nurses, social workers and others) who are in contact with young children are provided with the appropriate knowledge and standardized tools to be able to assess the psychological condition of young children, and thus to assess the need for intervention. Therefore, the assessment and identification of pediatric psychological trauma is a new and burgeoning field of interest.

International Inspiration

In 2010, a large international consensus conference on pediatric psychological trauma was hosted by the University of Southern California. This was a very new and interesting initiative which primarily focused on the assessment of traumatic experiences in very young children. The Danish National Center of Psychotraumatology followed this initiative with great interest. Unfortunately, we were unable to attend the conference. Given the limited awareness of this important field of research in Denmark in comparison to the U.S., we decided to replicate the event in the hope of stirring interest in the field and thus enhancing the development of the field within Denmark.

Three of the presenters from the American consensus conference (Dr. Stacy Drury, Tulane University; Dr. Janet Rennick, McGill University; and Professor K. J. S. Anand, University of Tennessee) and four other leading scientists from Israel (Sam Tyano and Miri Keren, Tel Aviv University), England (Professor Jonathan Green, University of Manchester) and Norway (Dr. Mia Myhre, Norwegian Centre for Violence and Traumatic Stress Studies) agreed to come to Denmark and present their particular research areas within the larger field of pediatric psychological trauma. For the conference in Oslo, Dr. Nancy Kassam-Adams (Children's Hospital of Philadelphia) was an invited speaker as a specialist of traumatic stress in injured children.

Research Facilitation and Dissemination via Cross-National Collaboration

The Danish center collaborates with many international units and researchers on a daily basis. One of the reasons for this is that Denmark is a small country and in order to keep up with the fast-paced developments in the rest of the world, we need to engage ourselves in multinational collaborations. Furthermore, given that Denmark is a relatively quiet country when it comes to psychological trauma, it is natural for us to collaborate with countries which have higher prevalence of trauma and in which other aspects of psychotraumatology are being studied. These collaborations make us aware of new aspects

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within the field and continually inspire us in relation to our own projects. One of our closest collaborators is the Norwegian Centre for Violence and Traumatic Stress (NCVTS). Upon hearing about our forthcoming conference in Denmark, the NCVTS suggested that we collaborate in hosting the conference and that we divide it into two separate events each spanning two days. Their suggestion became a reality and, given the success of the collaboration, we highly recommend this type of collaboration when holding conferences or other large scientific events.

Shared hosting provided a number of long-lasting advantages:

- 1) Sharing transportation expenses for the presenters was an economic benefit for both centres.
- 2) Sharing presenters made it easier for the presenters since, instead of travelling back and forth, they could travel directly from Denmark to Norway and were therefore able to “get more done” in less time.
- 3) Collaboration after the conference was facilitated. With ongoing discussions of what have we learned and what can we learn from each other, we find it easy and meaningful to compare national initiatives and inspire each other.
- 4) Collaboration on research projects also was facilitated. Future research in the field of pediatric trauma will benefit from the exchange of data and comparisons between our two countries.

Collaboration After the Conference

After the conference in Denmark, we established a consensus group which consists of 15 relevant health professionals. Over the next four months, this group will develop guidelines and recommendations for future research needs and new assessment methods in pediatric psychology for use in hospitals, institutions, private practices, etc. With the current lack of attention to this topic in Denmark, these recommendations are very much needed given that assessment and early intervention of potentially traumatized children can prevent or reduce later psychopathology. The resulting recommendations and guidelines, which will be based on best current practical experience and research, will be sent to the Danish Ministry of Health. We hope that by doing so, we will raise government awareness on this topic.

In Norway, all the regional polyclinics have signed agreements to further develop their offerings in the area of pediatric psychological trauma and the initiative has become a high priority. We in Denmark are following this Norwegian initiative closely. In conclusion, we strongly recommend that trauma researchers and clinicians look beyond the limits of national collaboration when arranging large events and research projects. It is beneficial to share and compare – it reduces expenditures, provides new inspiration and enhances the exchange of knowledge.



Advice for International Collaborations

Denmark has very strict visa rules which became problematic for one of our presenters, Professor Anand. Due to the fact that he was an Indian citizen, Professor Anand was not able to travel to Denmark without going to the Danish embassy in Washington, D.C. This was, of course, both time-consuming and expensive and so we had to create an alternative solution. As a result, Professor Anand held his lecture as a webinar.

This was a great success and therefore we would like to take this opportunity to recommend the webinar format to anyone who experiences similar problems. A video connection is a very useful tool to minimize financial expenses and yet still get the best of a research presentation.

Traumatic StressPoints Leadership

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V World Congress on Traumatic Stress “Addressing trauma in medical, emergency and mental health settings”

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Centro Banamex
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The congress will bring together more than 1,500 professionals from five continents in a unique opportunity for sharing different experiences from different realities and perspectives. For more information about the program, visit the [Preliminary Program](#) for a detailed list of the confirmed speakers.

Information and registration: <http://www.5tswc.org/>

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March 28 – 31, 2012

“Being a Healing Presence in a Hurting World”

[Association for Death Education and Counseling \(ADEC\)
34th Annual Meeting](#)

Atlanta, Georgia, USA

March 29 – 31, 2012

“There are Many Walls to Take Down – On the Way to
Integration”

[3rd Bi-Annual International Conference of the European
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