Let me extend my warmest wishes to all of us for a prosperous and peaceful 2009. So far, in these first few days of the year, with fighting in the Gaza, continued wars elsewhere, and the worldwide economy suffering, it doesn’t look like my wishes will come true; but that is what wishes are for, maintaining hope. On a more mundane but controllable level, hopes and plans for ISTSS are the themes of this column for January. As we start the new year for ISTSS, I want to let you know about some activities that we will be launching in the hopes of better meeting the needs of our members and potential members.

The first one should be obvious to you. We have moved StressPoints out from the members-only section into the public area of the Web site. While the newsletter has been considered a benefit of membership, our members were reading it less often because of the need to enter a user ID and password. We are all so burdened with our various user IDs and passwords, that getting to the newsletter was becoming more burden than benefit.

We need to think through how we want the Web site to look and how we want it to function for our members, and other constituencies. For example, do we want the Web site to serve only the members and potential members, or do we want the Web site to have sections for the public, the media, or policy makers? If so, who would take on the tasks of populating, updating and maintaining those sections of the Web site? As a membership organization, these types of activities happen because of volunteers. So we need, not just good ideas, but volunteered effort.

What new or updated sections of the Web site would benefit our members the most? If you have not looked into the members-only section, please take the opportunity to do so. The Dissemination Task Force, under the able leadership of Mark Creamer, developed a section of the Web site to gather and disseminate public domain assessment measures and therapy manuals that have been tested and found effective and reliable. The Dissemination Task Force was also working on assembling materials that had been translated and tested in other languages. Though the Dissemination Task Force has completed their short-term task, the Web site Committee will now take over the duties of seeking out and updating that section of the Web site.

Debra Kaysen is serving as the interim Web site editor (dkaysen@u.washington.edu). If you are interested in serving on either the Web site Task Force for planning or the Web site Committee for implementation, please contact Nancy Kassam-Adams or Debra Kaysen. You can also forward any ideas that you might have about the Web site to them as well.

Finally, if you did not see the email that came out before the holidays, when you are planning on ordering something, anything, through Amazon, please start from our http://astore.amazon.com/istss-20. If you do, a portion of the profits come back to ISTSS to help support the organization.
A Case Report from China: The Little Girl in the Aftermath of the Earthquake

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Translation: Yin Song², BS., & Glen L. Xiong³, MD

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Eulogy: The Duke Voluntary Medical Team (DVMT), worked with victims of the May 12, 2008 earthquake in China between August 23 and September 7, 2008 in cooperation with physicians and psychologists from Huaxi Hospital in Chengdu Sichuan. Mei Wang, the head of psychological counseling for the Huaxi Hospital team has shared this case report with us. I read it with tears. I am deeply touched by her beautiful work and by knowing that a Western psychotherapy approach can be well received in my motherland where the minds of the people had been dominated by Maoism for decades.

At 2:28 PM on May 12, 2008, an earthquake of 8.1 on the Richter scale struck southern China resulting in 79,800 casualties, 17,300 missing and 10 million displaced individuals. Because of the great number of casualties and missing bodies (more than 10,000 of them school children), the massive damage, the vast area involved, and the limited number of mental health providers available in China, post disaster mental health recovery has been tremendously challenging.

Mei is a member of the Psychoanalytic Association of Chengdu, Sichuan University who has been receiving formal psychoanalytic training for several years. Following the earthquake, she, along with many other mental health professionals, have taken a long leave of absence from their regular jobs and have devoted themselves to the provision of post disaster mental health care in the earthquake zone. Although psychological services in China are still at an early stage of development, the enthusiasm and skill that Mei and her colleagues have brought to their work has been highly encouraging and reassuring.

- Wei Jiang, MD.
  Head of the DVMT
  Associate Professor, Psychiatry and Internal Medicine
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I saw a four-year-old Tibetan girl on the afternoon of May 26, 2008, under a big Banyan tree in an earthquake refugee camp.

Upon hearing this, I introduced myself and my occupation to the woman and the girl. I expressed my wish to work with them and hoped that they would be interested in working with me as well to help the girl recover. Her aunt immediately agreed so I knelt down in front of the girl and looked into her eyes, "I will come and play with you tomorrow morning at 10. Is that okay?" She did not respond but I saw a flicker in her eyes. I believe that she must have heard me.

After leaving, I started to think about how to start the intervention process. It was the last day of the second week post disaster. The girl had consistently been in a collapsed state since the earthquake and her mother’s death. Her mind is frozen in desolation because of the loss of her mother. Her condition had lasted two weeks and starting psychotherapy at this point seemed reasonable. For a four year old, her emotional attachment to her mother is an important starting point. Although her ability to express herself is limited at her age, if I help her develop a greater sense of security and gain her trust, she might be better able to express her inner feelings. These are the critical starting points. At each meeting, I will tell her when our session will end and when the next session will start so as to better define our relationship and help her better manage interruptions in our work and any related sense of loss.

At 10 am the next day, I brought children’s books, colored pencils and blank paper to her living quarters. It was fortunate that all of her roommates were out so I closed the door,

Please see Little Girl on page 3
showed her the stuff I brought with me and asked if she wished to listen to a story or to draw. She continued to lie quietly on the bed close to her aunt but her head turned towards the story books. I asked, “Tell me which one you like?” She pointed to “The Ugly Duckling”. I asked if she would like me to read the story to her. She did not give an affirmative response but I opened the book and started from the beginning. (Since this was my first time working with her, a transference relationship had not fully developed. If I had asked her aunt to leave, it would likely have working with her, a transference relationship had not fully developed. If I had asked her aunt to leave, it would likely have increased the girl’s anxiety beyond her capacity to work with me. Also, because her aunt did not understand the nature of my work, she stayed this one time).

While I told her the story, I purposefully asked her if she could see what was on each page every time I turned a page. She would not answer so I would start reading the next page. It was a story about a little duckling growing up alone. It described details of the family of the duckling as well. (Although she chose the story at random, and she does not have the same background as the little duckling, they both share the similar fate of a lonesome existence.) After I finished reading her the book, I asked her if she liked the story. She glanced at me without any expression but then she suddenly said, “Red-egg cheek!” [A literal translation from Chinese, hong lian dan means rosy cheeks.] (The little duckling in the story has rosy cheeks.)

I responded immediately, “Just like your red-egg cheeks, right?”

In response, she slapped the book on the bed with both hands and I realized that our work had begun. I informed her that I would see her the next day and asked if that was okay. I also asked her to tell me the “Ugly Duckling” story when I saw her tomorrow. Additionally, I asked her if I could play with her on our own [without the aunt]. She started crawling around on the bed.

That night, I realized the importance of listening and being patient with the child. When she is willing, she will relive the experience of her mother and process her mother’s death through pictures or imaginary play.

During our second meeting, she was willing to let her aunt go and work with me by herself. She also asked to sit on my lap. I let her and said, “We are good friends now. Can you please tell me a story today?” While flipping through the “Ugly Duckling”, she started to tell me the story of the little duckling, but her version was different from that of the book. She said that the mother of the duckling was swimming in the river and left. The mother did not want the little duckling anymore so she disappeared. I asked if the little duckling felt bad since she couldn’t see her mom anymore.

“The little duckling will play by herself,” the little girl responded. I asked, “Will the mom come back?” She refused to answer, threw the book away and said, “Finished.” (At her age, she is best able to reflect her true feelings through play and she does not have a firm grasp on the reality and nature of death. Whether or not the dead mother can return to her is uncertain in her mind. Therefore, one aim of the therapy would be to resolve her doubt in a realistic and helpful way.)

At our third meeting I found that she likes to hold my hand. I asked her, “What should we play today?”

She opened the box of colored pencils, picked up an orange one and drew several curved lines. “This is candy I drew for you.” Immediately thanked her and told her, “I know you like me.” (The transference has emerged through which she will begin to reveal her as yet suppressed emotions. Her internal inclinations will naturally manifest so that she may recover and become strong.)

During our fourth meeting she still chose to draw. This time she picked the pencil which was sky blue. She drew several lines and irregular shapes. Then she said she wanted to fold the paper into an airplane. I asked her, “Who is on the airplane?”

Rather than answer my question, she explained the flight from Yingxiu (another area that had been severely damaged during the earthquake) to Wenchuan. “There were so many people on the airplane, it was like a pig sty. The driver of the airplane said, ‘Don’t talk!’ and then leaned over and fell asleep.” After saying this, she started violently stabbing the plane with the pencil and forcefully biting the pencil. (I felt that she was starting to reminisce about her experience.) After our session, I asked her aunt how the girl arrived at the refugee camp. Her aunt said that she came out with a group of elder refugees by helicopter. The older children and middle aged people walked out of the mountains by foot.

During our fifth, sixth, and seventh meetings, she always started by drawing candies for me to eat followed by drawing the airplane. She said that it was so crowded on the airplane that people stepped on her feet causing her a lot of pain. When asked if she was scared of flying in the plane, she replied that she was. At each session she used a different color pencil to draw the plane: red, purple, and green. She told me that she will drive the plane to take me and other women to Dujianyan (close to Yingxiu). After she finished drawing the planes, she repeatedly stabbed the planes until the point of the pencil had receded into the wood shell such that no more of the colored graphite could be seen. One time she used the pencil to scratch the paper to pieces and declared it to be a “Xiang Long” (lucky dragon). Afterwards, she said that she will...
Little Girl from page 3

pulverize and kill the “Xiang Long”. She then called the pencil “Gui Er Zi” (an insult term used in China, mainly in Szechuan province to imply that someone does not know their parents or ancestors. Literally it means “the child of a turtle”).

I asked her, “Are you very angry? The airplane took you away from Yingxiu so you are far away from your Mom, right? You are angry at the airplane, right?” She did not answer but she stopped stabbing the paper. (Young children like her express their emotions through playing games or drawing, etc. These activities act as their defense mechanism against an intolerable reality. She will open up more once she knows that I understand how she feels.)

“Why do you want to go to my home?”

“Because I want to go to your home.”

“No we didn’t.” I responded.

“The shu shu in your home.” said the girl.

“Where is your shu shu?” I asked “Which shu shu?”

Wenchuan?” I asked “Which one?”

“Shu shu in your home.”

“She used to call out for her mother in her dreams. Now she calls for the aunt.)

During the next three sessions the girl used a red pencil to draw curved lines describing her understanding of her mother’s death. At one meeting she took the initiative of telling the “Ugly Duckling” story. She said, “The ma ma of the little duckling does not know where the ma ma went. The little duckling could not fly like that so she could not find ma ma. Ma ma closed the door and the house of the little duckling collapsed. Ma ma was not able to get into the house. A stone fell onto the little duckling’s head; but the little duckling was not scared. The dad’s hand and leg were broken. The duckling hid beside her ma ma because if she got out, she would be killed.”

She then started folding the airplane and talked some more. “I cannot see my ma ma anymore. She was flooded away. I was flooded into the canyon. Ma ma closed the door and the house of the little duckling collapsed. Ma ma was not able to get into the house. A stone fell onto the little duckling’s head; but the little duckling was not scared. The little duckling could not fly like that so she could not find ma ma. Ma ma closed the door and the house of the little duckling collapsed. Ma ma was not able to get into the house. A stone fell onto the little duckling’s head; but the little duckling was not scared.

At the next meeting, she continued, “The little duckling does not know where the ma ma went.” She told me that she dreamed about her mother the night before. I asked, “What was I doing in your dream?”

She responded with another question, “Did you and “shu shu” (term used to address men that are one generation above oneself. In this case, it most likely implies the husband of the therapist) visit Wenchuan?” I asked “Which shu shu?”

“The shu shu in your home.” said the girl.

“No we didn’t.” I responded.

“I want to go to your home.”

“Why do you want to go to my home?”

She turned her face shyly away from me. She put my bag on her back and said that she wanted to carry my bag to go to school in Wenchuan. She then asked if I have a younger sister. I told her that my daughter is older than she and should be her older sister. (She had lost her most loved person, her mother. In the course of our work, she had now developed a very strong transference to me to compensate for her loss. She started being more inquisitive about my family. I need to work with her transference in order to make progress in our work together. How would she move on in life after our psychological intervention ends? My mentor advised to use a transitional object as a replacement to help her move on.)

At the next visit, I brought her a doll made of flannel and candy. She initially ignored me. (I had not visited her the day before because of a schedule conflict) I asked, “Are you mad because I did not come yesterday to see you?” She responded with a yes. She then started drawing an airplane with me and “shu shu” sitting on the airplane. Next, she opened my bag and found more candies and asked to have more. I told her, “You opened my bag without my permission. I’m not happy. I can not give you anymore candy today. Those candies are for other children I am working with. You will have one candy each time we do our work together.”

At the end of the session, I told her that I will return to my home and come back to see her tomorrow at the same time. I will let her know if I cannot come. (I need to help her understand that I have my own family and other patients I need to attend to. We need distance between us. This will help to manage the transference and help her slowly understand the difference between fantasy and reality.)

On July 14th, the community held a grieving ceremony for all the refugees in the area. The proceedings included moments of silence, singing, and flower offering. Her aunt cried very hard during the memorial. I walked over to them, stood beside her aunt, picked up the little girl and held her. While crying, her aunt asked the girl, “Do you miss your mom?”

I asked her, “The teacher will miss the student after the teacher leaves. Will the student miss the teacher?”

The little girl suddenly turned her head away and her eyes glazed over. As I gently patted her back, her tears flowed out silently. I walked with her and her aunt to the riverside with a chrysanthemum flower. The girl tore the petals off the flower and threw them into the river. Her aunt said, “For your mother.” (The manifestations of PTSD may erupt any time. The defense mechanism of the sufferer can result in regression. What is the impact of my work? Her aunt noted that the girl used to call out for her mother in her dreams. Now the girl calls out for the aunt.)

During the 16th through 20th sessions, she and I played games related to attending school and going to classes. She had me play the teacher as she played the student. She asked...
me to praise her for being a good student with test scores good enough to get into college. On several occasions, she called me aunt. I asked her "Why do you call me aunt?" She smiled shyly.

Once while playing "school", I asked her: "The teacher will miss the student after the teacher leaves. Will the student miss the teacher? Will the student get mad at the teacher after the teacher leaves?"

At the end of each session, I always handed her to her aunt. She would then run to play with other women and children. They all liked her because she was lively and intelligent. (I believe that relying on her transference to allow her to believe that she is a good student is better than her going to my house (even though that would please me more). I understand that my work is to put myself in the position of her mother and act as a transitional object to help her process the loss of her mother rather than try to replace her mother in reality.)

On a Saturday afternoon after the 21st session, I received a phone call from her aunt who told me that they were leaving the refugee camp and getting ready to return home. They were at Huaxi (China West) Hospital visiting friends and wanted to say goodbye to me. I rushed to the hospital and met the girl, her aunt, her older sister and two relatives. I gave her a piece of candy, a pencil, and advised her to study hard. I told her that her aunt has my phone number so she could call me when she missed me. I also let her know that I would go visit her in the future. We then took a picture together.

What is the meaning of losing a mother to a four-year-old child?

According to psychoanalytic theory, a child of this age is in the oedipal stage of development during which she enters a triadic relationship with her parents and recognizes the mother's role as her competitor for the affection of her father within that triad. Thus the mother is ambivalently held at that point in development. The child needs the mother to be present and to survive that ambivalence in order to resolve the inherent conflicts of that period of development. During our brief course of psychotherapy, the loss of the mother as an important object was the focal problem. Accepting her mother's death meant more to her than simply accepting a terrible loss. It meant that she also had to suddenly come to grips with her own competitive feelings towards her mother and the guilt related to her having survived while her mother had died. At another level, coming to understand her loss meant having to accept a very different future as well as some harsh current realities. Having to accept such facts within such a short time is terribly threatening. I cannot replace her mother in her life. The focus of our work was to help her better understand and accept her mother's death, manage her sadness, fear and sense of guilt, adjust to a new and still uncertain future, mobilize her inner strength, grow stronger, and gain the confidence she needs to continue living. I cannot eliminate the pain of the disaster, the reality of her mother's death, or the horrific experience of the earthquake. The pain will likely go on but she will hopefully be better able to manage it. It is possible that the pain of these events will resurface again in the future. This may happen next year, in ten years, or several decades from now. What I can do now is help her to continue her life and help her develop her ability to move on despite any recurrence of such pain in the future!

Author's Notes

Acknowledgement: The author wishes to send her gratefulness to her supervisors: Irvin Milowe, MD (Professor of Psychiatry, University of Miami, Training and Supervising Analyst, Florida Psychoanalytic Institute, Coconut Grove, Miami, FL 33133), Hong Deng, MD (Associate Professor in Psychiatry, Mental Health Center, Huaxi Hospital Sichuan University, Chengdu, Sichuan 610041), Yanchun Yang, MD (Professor in Psychiatry, Mental Health Center, Huaxi Hospital, Sichuan University, Chengdu, Sichuan 610041).

* We respectfully and purposefully maintained Chinese flavor with certain phrases during the translation.

Note: The child's guardian gave permission for case information to be disclosed; details have been changed to protect the identity of the client.
Research Can Help Children’s Advocacy Centers (CACs) Improve Services to Child Sexual Abuse Victims

Lisa M. Jones
Crimes Against Children Research Center (CCRC), University of New Hampshire

Children’s advocacy centers (CACs) are agencies designed to coordinate multidisciplinary investigations of child abuse in a child-friendly environment. These agencies have spread rapidly in the United States and are playing an increasingly important role in the response to child abuse victims and their families. The primary focus of CACs is serving victims of child sexual abuse, although CACs are also involved in cases of serious physical abuse, children who witness domestic violence, and other cases involving child victim-witnesses. The CAC model integrates several different goals: reducing repetitive interviews for child victims; providing specially-trained child forensic interviewers; increasing multidisciplinary teamwork across investigating agencies; and linking victims and their families with specialized medical and mental health services.

The CAC model developed out of concern that traditional investigation practices were unduly stressful for children and often ineffective.

CAC professionals intend for their model to reduce investigation-related stress on children and promote the well being and recovery of victims and their families. They can ensure continued progress toward these goals by drawing more directly from evaluation and service research and continually incorporating evidence-based practice into their work. Further, in their roles as community advocates for child victims and as multidisciplinary coalition builders, CACs are in an ideal position to actively encourage evidence-based practice by partner agencies. This article summarizes findings from the University of New Hampshire Multi-site CAC Evaluation Research and other CAC evaluations and outlines how research can help CAC professionals increase effective services for child abuse victims in their communities.

The CAC Model

The CAC model developed out of concern that traditional investigation practices were unduly stressful for children and often ineffective. One of the biggest concerns was that children were being subjected to multiple, repetitive, and insensitive interviews by untrained professionals [1-5]. Child forensic interviews were taking place in intimidating settings like police stations, adding further stress to already frightened children [4]. Furthermore, the response was hampered when the different investigatory agencies failed to coordinate their investigations, and children’s service needs were neglected [6].

In response to these concerns, the CAC model integrated several different investigation reforms: 1) the coordination of a multidisciplinary investigation team (typically including child protective service professionals, law enforcement, prosecutors, medical professionals, and mental health professionals); 2) the provision of a neutral, and child-friendly environment for child forensic interviews; 3) facilities to accommodate team forensic interviews in which one investigator interviews the child while other investigators observe through a one-way mirror or by closed-circuit television; 4) specialized training for child forensic interviewers; and 5) service linkages with medical and mental health providers in the community.

The growth of the CAC model has been rapid. The first CAC was established in 1985; in 1994 there were 50 CACs, and by 2008 there were over 600 CACs, with at least one in every state in the United States. Although the development and leadership of these agencies is community-based, a national membership organization, the National Children’s Alliance (NCA), was formally established in 1998. Among other leadership efforts, the NCA oversees an accreditation process where member CAC agencies are required to demonstrate that they meet key service standards.

Despite the widespread growth and importance of CACs, the field has lacked data about their impact. Recent evaluations conducted by our research center and others represent initial efforts to understand how successfully CACs have established new investigation procedures, and the effect of these reforms on investigation and service outcomes.

CAC Evaluation Research

The Multi-site CAC Evaluation Project led by researchers at the University of New Hampshire collected data on a wide range of anticipated benefits of CACs [7-10]. This project compared child, family, and system outcomes after an allegation of child maltreatment for 4 communities across the country with a CAC and communities in the same state without such centers. Data included a) case level data abstracted from agency files (N=1,500), b) research interviews with non-offending caregivers (n=360) and child victims (n=80), and c) descriptive site-level data. Findings included the following:

- Communities with CACs had greater law enforcement involvement in child sexual abuse investigations and more evidence of coordinated investigations.
- CACs increased children’s access to forensic medical exams.
- Caregivers at CACs expressed greater satisfaction with the investigative process than those in communities without CACs.
- CACs documented a higher rate of referrals for child mental health treatment, although children accessed...
mental health treatment at similar rates across CAC and comparison communities. Across all communities, an average 70 percent of children with a clinical need were receiving mental health services.

- CACs did not show evidence of fewer child forensic interviews. In both CAC and comparison communities reported sexual abuse victims experienced only one or two forensic interviews.
- CAC and comparison communities had similar rates of arrest, prosecution and conviction of offenders.
- The CACs in the study all met NCA standards; however, the structure, procedures and outcomes at each CAC varied widely.

Recent smaller-scale CAC evaluation research has replicated some of the findings of our project. One study found that CAC cases included higher rates of law enforcement involvement, medical examinations, and case substantiation by child protective services when compared to non-CAC cases [11]. Another study found that CAC cases and cases from a multidisciplinary Child Protection Team in Florida showed improved substantiation rates and faster family court case resolution timeframes than non-coordinated cases [12].

**Implication of Evaluation Results for CACs**

CAC professionals hoped that the first comprehensive evaluations would verify the stated goals of the model: reducing child interviews, improving criminal justice outcomes, and improving service delivery. We believe the findings offer solid support for CAC practice, particularly given they are the first evaluation results to have been published. However, the findings from these studies also raise a number of important questions about CAC practice that need to be answered and should encourage active discussion by CAC professionals: What do the variations across CACs mean for the goals CACs are trying to achieve? Should there be benchmarks of practice that CACs should set as specific goals—for example in levels and types of coordination, medical and mental health service access and quality, and client satisfaction levels? How can research be more formally integrated into the development of the CAC model as it evolves?

We have recommended several next steps for CACs based on the findings:

- CACs should emphasize their skills in improving coordination, facilitating services, and working with families…
- CACs should continue to increase levels and quality of medical service helping to ensure that child victims receive exams from trained medical professionals. Medical exams were provided more frequently in CAC samples than in comparison samples, but rates still varied across agencies. It is encouraging that, with initiative from the medical community, NCA has recently increased the details and rigor of the medical service accreditation standards for member CACs.
- CACs should make greater efforts to track mental health service referrals and increase access to evidence-based services. Importantly, CACs could help to improve readiness for evidence-based treatments for child trauma in their communities by increasing practitioners’ awareness of the needs of child abuse and trauma victims, helping the community become more aware of evidence-based treatments in this area, and by facilitating communication across multidisciplinary child abuse teams. NCA resources such as the CAC Directors’ Guide to Mental Health Services encourage CAC professionals to help disseminate evidence-based treatments for child traumatic stress.
- CACs could help to address some of the remaining complaints from children and caregivers about the investigation process. Non-abusive caregivers regularly described wanting more frequent communication about the case. Dissatisfaction of caregivers and children was particularly high when the case was unfounded or when prosecution was not being pursued. Even when investigators do not pursue allegations, child and family distress is often high and connections with support services still needed.

**What Do the Evaluation Results Mean for the Child Abuse Field?**

The evaluation results also raise critical questions about the current state of knowledge on investigation practices in general. The CAC model incorporates a set of discrete investigation procedures that are not unique to CACs. Many communities have established a multidisciplinary team for the purpose of reviewing procedures in particularly complex child abuse cases. In many communities, law enforcement and child protective services coordinate their investigations and conduct joint forensic interviews. Links between law enforcement agencies and crisis advocacy or mental health programs have also been established in many communities to improve victims’ access to services. And improving access of children to specially trained forensic interviewers, medical professionals and mental health practitioners is a goal toward which many professionals in the field are aiming.

Yet we actually knew very little about the implementation success or outcomes of these efforts [13]. To their credit, CAC advocates have successfully created a well-organized model...
that incorporates multiple procedures experts suggest are the best ways for a community to respond to an allegation of child sexual abuse. Establishing a CAC is a way to implement multiple investigation reforms efficiently, and with the assistance and recognition of a national support network. However, the “effectiveness” of the CAC model is fully tied to the cumulative effect of the various practices that are implemented.

The question, “Do CACs work?” actually conceals a number of more complicated and important questions we have yet to answer. Under what circumstances do multidisciplinary teams work best and with what outcomes? Does interviewer training improve children’s experience, the extent of information obtained, or criminal justice outcomes when implemented in field conditions? Do team interviews improve information sharing? Do multidisciplinary case reviews improve the outcomes of more complicated cases? Does information sharing lead to improved outcomes for the child, the case, or the community? Is it better to have multidisciplinary teams co-located? What are children’s experiences when mental health and forensic interviewing are provided in the same location? What is the best way to help victims of child abuse access more efficacious treatment? Can case-tracking improve service delivery, how and under what circumstances? Child abuse and CAC professionals and policy-makers need to insist on the answers to these questions from researchers and need to apply the findings to practice when they become available.

An exciting opportunity for CACs

CACs have an opportunity to be an active part of a push to raise the standard of service for child abuse and trauma victims and families to an even higher standard during the next several decades. The studies described above could serve as a springboard for CAC leadership to promote a model of research-service integration. This could involve an ongoing pattern in which CAC investigation reforms are evaluated regularly and research-based improvements are formally incorporated as key components of the CAC model. CACs could serve as models for formally and systematically incorporating available research into child abuse investigation and service. Agencies could aim to use research findings on a regular basis to inform their membership standards and establish benchmarks or measurable goals for their work

We recommend that CACs adopt the best practices that research supports and participate in research themselves to help identify what works. CACs could consider and promote their work not as a new approach to serving victims of child abuse but instead as an evolving and structured model for bringing to a community research-based strategies to: 1) help the community investigate and respond to child physical and sexual abuse as sensitively and effectively as possible; 2) bring more evidence-based programs and specially trained professionals to their community; and 3) link victims to the best services available.

Following this definition, there would be less emphasis on CACs needing to “prove” their “approach” works, which may be difficult given the complexities and varieties of CAC practice and the little research currently available on investigation practices in general. Instead, the test of a CAC’s effectiveness would be the degree to which research-based practices were adopted by the CAC and partner agencies as they became available.

References

The Lifetime Achievement Award was presented to Dr. Dean Kilpatrick at the ISTSS Annual Meeting in Chicago this last November. This award is the highest honor given by ISTSS. It is awarded to an individual who has made great lifetime contributions to the field of trauma.

Dean Kilpatrick has been an active researcher in the traumatic stress field since 1976. He conducted one of the very first studies on the topic of rape, a prospective study of fear reactions, and published one of the first papers analyzing rape-related mental health problems from a cognitive behavioral perspective. He was also involved in one of the very first treatment outcome studies and helped to modify stress inoculation training for rape victims, a therapy which is considered today as one of the evidence-based treatments for PTSD.

He has an impressive research record with 224 publications, of which 159 are in peer-reviewed journals and 65 are books, book chapters, or monographs. Dr. Kilpatrick has served as Principal Investigator or Project Director on over two dozen research projects in the traumatic stress area, funded by the Veteran’s Administration, National Institute of Mental Health, National Institute on Drug Abuse, Centers for Disease Control, National Institute of Justice, the Office for Victims of Crime, the State Justice Institute, the Health Resource and Services Administration, and the National Institute on Child Health and Human Development. Perhaps his greatest contributions are with epidemiological studies that have examined heretofore understudied populations. These studies have served as the basis for many other researchers to launch projects, for clinicians and advocates to develop programs, and have influenced public policy and changes in the law on both local and national levels.

With colleagues at the National Crime Victims Research and Treatment Center, which he founded, Dean pioneered epidemiological research that studied the scope, nature, and mental health impact of exposure to violence against women and children and other potentially traumatic events among representative samples. This work included five large studies using national household probability samples, studies that have provided the traumatic stress field with valuable information about the prevalence of exposure to potentially traumatic events, the characteristics of violent victimization, the prevalence of PTSD and other disorders, and the extent to which these events increase risk of PTSD and other disorders.

He and his colleagues also used epidemiological methods to study the impact of terrorist attacks including the September 11th World Trade Center attacks and the Pan Am Flight 103 bombing, the 1992 urban riots in Los Angeles, and several natural disasters, including Hurricanes Andrew and Hugo, the 2004 Florida Hurricanes, and the 1989 Loma Prieta Earthquake.

...he has worked collaboratively with practitioners, non-government organizations, and governmental agencies.

He and colleagues have also conducted several studies looking at preference for and implementation of crime victims’ rights legislation and how that is related to victim satisfaction and mental health. This research has been cited in law review articles, state and national legislative debates regarding victims’ rights legislation, and in court decisions.

He and his team have recently pioneered new work collecting DNA from probability samples of adults interviewed via telephone. This work is looking at how specific candidate genes modify the effects of environmental exposure to hurricanes and social support with respect to the phenotypes of PTSD and depression.

An important aspect of his research is that he has worked collaboratively with practitioners, non-government organizations, and governmental agencies. He has also made a special effort to disseminate the results of his research to policy makers as well as the general public. For example, the Rape in America report was covered extensively by virtually every national media outlet and was viewed, heard, or read over 104 million times within two weeks of its release.

For a body of research and scholarly writing that has influenced the field of traumatic stress internationally, The ISTSS is honored to recognize Dean Kilpatrick with our highest award – the Lifetime Achievement.

Visit the ISTSS Amazon Store!

The ISTSS Amazon Store (also accessible from the ISTSS homepage) features trauma-related books for professionals and the public, as well as fiction, memoirs, and movies with themes related to trauma and healing. The store allows ISTSS members and others to locate useful resources, while helping to support ISTSS.

Bookmark the ISTSS store and begin your Amazon shopping! ISTSS earns a referral fee of 4% to 10% for items purchased through the site. Any Amazon purchase that originates through our store helps to support ISTSS. To find other Amazon items, just click the “Powered by Amazon” button in the upper left corner of the page and continue shopping.

Please send suggestions to Nancy Kassam-Adams at nlkaphd@mail.med.upenn.edu.
Trauma and World Literature: Top 10 Movies

Harold Kudler, M.D.

As noted elsewhere in this issue, ISTSS is partnering with Amazon to create an on-line store (accessible from the ISTSS homepage) featuring professional books, nonfiction, fiction, poetry, documentaries, dramas and other works (including books by ISTSS members) on the theme of psychological trauma, its effects, and how people survive it. We hope this will foster more interest in the connection between trauma science, practice and the arts and we dedicate this installment of our column to Harold’s top 10 picks of movies that reflect essential truths about psychological trauma. Howard assures me that his list would largely overlap mine and particularly wants to endorse my first choice as an illustration of how even veterans returning victorious find homecoming from war to be rife with challenge.

1) **The Best Years of Our Lives** (1946): Winner of the Academy Award for Best Picture. Three World War II veterans return home to find that they, their families and their town have changed.

2) **All Quiet on the Western Front** (1930) A young German soldier is stripped of his illusions amid the grim realities of World War I.

3) **The Pawnbroker** (1965) A Holocaust survivor struggles to repress his memories at the risk of losing himself.

4) **Schindler’s List** (1993): An opportunist is transformed in the course of the Holocaust.

5) **Apocalypse Now** (1979): Joseph Conrad’s *Heart of Darkness* reset in Vietnam as a study of psychological trauma and its effects upon those caught up in it.

6) **Saving Private Ryan** (1998): Perhaps the most successful effort to realistically represent the experience of battle in film.

7) **The Sweet Hereafter** (1997): A quirky, haunting study of a lethal school bus accident, its effects on a community and a man who cannot accept what happened.

8) **Twelve O’Clock High** (1949): The new commander of an American bomber group relentlessly wears himself down as he leads his men to fight with “maximum effort.”

9) **A Night to Remember** (1958): The sinking of the Titanic portrayed in its human dimension without distracting special effects or romantic storylines. An unforgettable depiction of people facing disaster.

10) **Home of the Brave** (2006): Hearkening back to *The Best Years of Our Lives* but set 60 years later, three Iraq War veterans struggle with readjustment upon their return to a small American town.

We want to know which movies, books or other artistic expressions our readers would choose as their top choices. In compiling your list, consider those works you have found helpful to discuss with patients or recommend when you teach. Please write to Harold Kudler and Howard Lipke at HLipke@aol.com. Your selections may be featured in a future column and are also likely to be included on the virtual shelves of the ISTSS Amazon store!

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Be Part of the Program: ISTSS Call for Presentations

February 2 – March 16

This year’s meeting theme is “Traumatic Stress Disorders: Toward DSM-V and ICD-11.” Our primary objectives are to provide a forum to consider how we define and conceptualize problems of posttraumatic adjustment with an eye toward upcoming revisions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) classification systems.

Beginning Monday, February 2, ISTSS new members, experienced members, nonmembers, and students are invited to submit presentation proposals online for possible inclusion in the 25th Silver Anniversary Annual Meeting in Atlanta, Georgia, USA from November 5-7, with pre-meeting institutes held on November 4. The submission deadline is March 16, 5:00 p.m. CDT (no exceptions).

Download the Call for Presentations now and begin preparing your submission: [http://www.istss.org/meetings/ISTSS_CFP_09.pdf](http://www.istss.org/meetings/ISTSS_CFP_09.pdf)

Potential Topics:

Categorical versus dimensional approaches to classifications  I  Biomarkers of diagnoses  I  Differential diagnosis  I  Treatment matching  I  Cross-cultural issues  I  Trans-national approaches  I  Public and mental healthcare policy implications  I  Ethical issues  I  Training and education  I  Forensic issues

Submissions on other topics relevant to the traumatic stress field are always welcome such as war, terrorism, refugees, child abuse, victim assistance, etc. International participation is strongly encouraged.

Questions? Contact Paula Borman at ISTSS Headquarters:

Phone: +1-847-480-9028 X357; Fax: +1-847-480-9282

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Boston University School of Medicine and The International Society of Traumatic Stress Studies. Boston University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians. Boston University School of Medicine designates this educational activity for AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.
NEW FROM THE GUILFORD PRESS

Effective Treatments for PTSD, Second Edition
Practice Guidelines from the International Society for Traumatic Stress Studies

Available in the ISTSS Amazon.com store!

Edited by Edna B. Foa, PhD, Center for the Study and Treatment of Anxiety, Department of Psychiatry, University of Pennsylvania; Terence M. Keane, PhD, National Center for PTSD, Veteran Affairs Boston Healthcare System, and Department of Psychiatry, Boston University; Matthew J. Friedman, MD, PhD, National Center for PTSD, VA Medical Center, White River Junction, VT, and Department of Psychiatry, Dartmouth Medical School; and Judith A. Cohen, MD, Center for Traumatic Stress in Children and Adolescents and Department of Psychiatry, Allegheny General Hospital, Pittsburgh, PA

Developed under the auspices of the PTSD Treatment Guidelines Task Force of the International Society for Traumatic Stress Studies, this tightly edited work is the definitive best-practice reference for practitioners caring for any trauma population. Leading clinical scientists thoroughly review the clinical and research literature on widely used therapeutic approaches. Succinct treatment guidelines are then presented that feature standardized ratings of the evidence for each approach. The second edition has been revised and expanded to incorporate important advances in the field, including a wealth of new data on child and adolescent therapies.

New to This Edition
*Expanded with six additional chapters on child and adolescent treatments.
*Adult chapters are fully updated (or rewritten) to reflect the rapidly growing evidence base.
*New chapter on treating other psychiatric problems that co-occur with PTSD.
*More coverage of early intervention and prevention.

KEY POINTS
- Completely updated and with 60% new material.
- Definitive: sponsored by the International Society for Traumatic Stress Studies, the leading association in the field.
- The combination of best practices, high-profile contributors, and a prevalent problem adds up to perennial demand.
- Editors are well-known authorities who present their work widely.
- Coverage of child and adolescent treatment has been greatly expanded.

*Coming Soon – The individual Treatment Guidelines will be accessible on the ISTSS Web site—check back often!
http://www.istss.org

ISTSS IN THE NEWS: Air Force Times
Headline: Study: PTSD Rates Higher for Troops who Kill.
Author: Kelly Kennedy
Article begins: "New research presented at the International Society for Traumatic Stress Studies shows posttraumatic stress disorder rates are higher in service members who have had to kill someone."
Read more.

The Dart Award for Excellence in Coverage of Trauma
The Dart Awards for Excellence in Coverage of Trauma recognize exemplary journalism on the impact of violence, crime, disaster and other traumatic events on individuals, families or communities. Entries should focus on the experience of victims and survivors, and contribute to public understanding of trauma-related issues. For more information, visit the Dart Web site.
ISTSS Sets Annual Conference Attendance Record
Looking Ahead to Atlanta, Georgia

From Chicago…

This past November, a record-breaking 1,435 experts in traumatic stress gathered in Chicago, Illinois for the 24th ISTSS Annual Meeting.

If you were unable to attend, or just want to relive and review the outstanding educational program, order the 24th Annual Meeting CD. Enjoy audio and visual components of available presentations captured at the meeting.

For information on additional past meetings, check out the meeting archives available on the ISTSS Web site.

To Atlanta…

In just ten short months, ISTSS will gather again in Atlanta to enjoy another outstanding meeting.

Be a part of the program! Beginning February 2nd, submit your abstracts for consideration for the ISTSS 25th Annual Meeting.

For more information on abstract submission or about the meeting, visit the ISTSS Web site.

Call for Papers: Special Issue of Psychological Trauma:
Theory, Research, Practice and Policy on Diversity and Trauma

*Psychological Trauma: Theory, Research, Practice and Policy* invites submission of empirical papers, scholarly reviews (including quantitative reviews), and legal and policy analyses which focus on the overlap between diversity, trauma exposure, and post-traumatic outcomes, for consideration in a Special Issue on Diversity and Trauma, to be edited by Nnamdi Pole and Elisa Triffleman.

The term “diversity” is here used to indicate diversity related to race, ethnicity, sexual orientation, gender identity, and/or socioeconomic status.

Manuscripts must be consistent with the American Psychological Association’s usual submission guidelines as well as those specific to *Psychological Trauma*. Papers that do not follow the guidelines may be returned without review. Papers should be no more than 25-30 pages in length, inclusive of tables, references and figures. All papers will be peer-reviewed.

Please submit papers electronically through the Manuscript Submission Portal, and request consideration for the Special Issue in an accompanying cover letter. *The deadline for submission is March 1, 2009.*

Questions regarding this, including queries regarding possible topics, may be directed to Elisa Triffleman, Chair of the ISTSS Diversity Committee, at elisatriffleman@earthlink.net.
Upcoming Events

February 16 - 21, 2009
The American Group Psychotherapy Associations (AGPA)
66th Annual Meeting
Sheraton Chicago Hotel and Towers, Chicago, Illinois, USA
www.agpa.org

March 4-6, 2009
The National Emergency Management Summit
Renaissance Washington D.C. Hotel
Washington, D.C.
www.emergencymanagementsummit.com

March 12-15, 2009
Anxiety Disorders Association of America
Anxiety and Health: Translating Basic Science into Practice
Hyatt Regency Tamaya, Santa Ana Pueblo, New Mexico, USA
www.adaa.org

March 23-24, 2009
UK Psychological Trauma Society First National Conference
The Evolution of Psychological Trauma Treatment
http://www.estss.org/confer/confer.htm

April 15-18, 2009
Association for Death Education and Counseling (ADEC)
31st Annual Conference
Hyatt Regency Dallas, Dallas, Texas, USA
www.adec.org/conf/index.cfm

May 14-15, 2009
British Trauma Society Annual Clinical Meeting 2009
British Trauma Society in association with Elsevier, publisher of the journal Injury
Newcastle Civic Centre, Newcastle, UK
www.trauma.elsevier.com

May 14-16, 2009
Use of the Internet in the Field of Mental Health
Sponsored in part by NATO, McGill University and the Douglas Institute
The Douglas Institute, Montreal, Quebec
http://www.douglas.qc.ca/internet-mental-health

June 15-18, 2009
The Norwegian Centre for Violence and Traumatic Stress Studies
11th European Conference on Traumatic Stress (11th ECOTS)
Oslo, Norway
www.ecots2009.com

June 24 to 26, 2009
X International Congress on Traumatic Stress
Panamericano Hotel & Resort - Buenos Aires, Argentina
www.psicotrauma.org.ar