

**Friday Concurrent Sessions**  
**8:30 a.m.–9:45 a.m.**

**Poster Presenters of Track 4, Clinical and Interventions Research will be available to discuss their posters.**  
**Grand Salon V, 3 (GB)**

**The National Child Traumatic Stress Network**  
**Forum (child) Galena, 4 (HB)**

*John A. Fairbank, National Center for Child Traumatic Stress, Duke University Medical Center; Robert S. Pynoos, National Center for Child Traumatic Stress, University of California, Los Angeles; Dennis J. Hunt, International C.H.I.L.D., Center for Multicultural Human Services, Falls Church, VA; Robert DeMartino, Programs in Trauma and Terrorism, Center for Mental Health Services, SAMHSA*

The mission of the recently established National Child Traumatic Stress Network (NCTSN) is to raise the standard of care and improve access to services for traumatized children and their families in communities throughout the United States. The goals of the Network are to define the problem of child traumatic stress; develop evidence-based, developmentally-sound assessments, interventions, and treatments; and work to create and coordinate a national network of organizations and institutions that provide mental health services to children and families. The National Network unites the efforts of many organizations serving traumatized children and provides a national framework to highlight their experience, expertise, and success. These links are designed to strengthen the efforts of all the Network members and improve the quality and availability of services for traumatized children. Ten Intervention Development and Evaluation Programs are primarily responsible for development, delivery, and evaluation of improved treatment approaches and service delivery models within the National Child Traumatic Stress Network. Twenty-five Community Treatment and Service Programs primarily engage in implementing, in the community or in specialty child service settings, model treatment interventions and community services for children and their families who have experienced trauma. Panelists will describe and discuss the progress and challenges of the NCTSN during the first year of operation.

**All You Ever Wanted to Know About Applying for Training Grants**  
**Forum (train) Grand Salon IV, 3 (GB)**

**Endorsed by Student Section, Gender and Trauma Special Interest Group, and Research Methodology Special Interest Group**  
*Karestan Koenen, Boston Medical Center and National Center for PTSD; Margaret Feerick, National Institute on Child Health and Development; Peter Delany, National Institute on Drug Abuse; Harold Perl, National Institute on Alcohol Abuse and Alcoholism; Farris Tuma, National Institute of Mental Health*

This workshop is sponsored by the Research and Student SIGs and was organized at the request of their members. This workshop is oriented toward students, post-doctoral fellows, and junior faculty who are interested in learning more about funding mechanisms available for education, training, and pilot studies in the area of trauma and PTSD. Representatives will be present from the National Institute of Mental Health, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Child Health and Development. These representatives will discuss funding mechanisms available for training (NRSA's, K-awards, etc.), who is eligible for which mechanisms, and how to put together a successful application. Students and junior faculty who have been successfully funded by these grants will also be present to answer questions from the audience.

**Comorbidity and Correlates of Substance Use Across Trauma**  
**Symposium (complex) Grand Salon VII, 3 (GB)**

*Paige Ouimette, Washington State University*  
 Documenting and understanding the comorbidity of trauma, PTSD, and substance dependence is an important endeavor. This symposium presents useful new information on this comorbidity and on substance misuse among trauma-exposed individuals. Presentations include a general population survey and research on inner city adolescents, veterans, and disaster-exposed individuals.

**PTSD and Substance Use Disorder: Epidemiologic Evidence**  
*Howard Chilcoat, Johns Hopkins Bloomberg School of Public Health; Naomi Breslau, Henry Ford Health Sciences Center*

Although there is a high degree of comorbidity between PTSD and drug use disorders, few studies have used longitudinal data from epidemiologic samples to explore causal relationships between PTSD, traumatic events, and drug use disorders. We present results from a longitudinal study of young adults in which 1007 21-30 year olds were initially assessed in 1989 and were followed up three, five, and 10 years later. To take into account temporal sequencing, the associations between PTSD, traumatic events, and drug use disorders were analyzed using Cox proportional hazards models with time dependent covariates. PTSD signaled increased risk of drug abuse or dependence. The risk for abuse or dependence was the highest for prescribed psychoactive drugs. There was no evidence that preexisting drug abuse or dependence increased the risk of subsequent exposure to traumatic events or the risk of PTSD following traumatic exposure. Additional analyses will examine the relationship of repeated exposure to traumatic events and PTSD to drug use disorders. The results suggest that drug abuse or dependence in individuals with PTSD might be the inadvertent result of efforts to medicate symptoms, although the possibility of shared vulnerability to PTSD and drug abuse or dependence cannot be ruled out.

**Substance-Abuse Related Deaths Among Veterans Treated for PTSD**  
*Kent Drescher, National Center for PTSD, VA Palo Alto Health Care System; Craig Rosen, National Center for PTSD, Stanford University; David Foy, Pepperdine University; Thomas Burling, VA Palo Alto Health Care System*

Previous studies have reported higher death rates among Vietnam veterans from external causes (including substance abuse), compared to other veterans and community controls. Veterans with PTSD are also known to have high rates of substance abuse/dependence. Yet few studies have examined causes of death specifically among Vietnam veterans receiving treatment for PTSD. Accordingly, the present study examined the mortality status of 1,866 male veterans who received residential PTSD treatment between 1990 and 1998. Death certificate information for the 110 veterans who had died prior to 2000 indicated that 30% of all deaths were directly attributable to either acute or chronic effects of alcohol or drug use. Another 32% of deaths occurred from other behavioral causes (accidents, suicide, homicide, HIV/Hepatitis) for which substance use is a risk factor. PTSD patients' causes of death differed significantly from expected causes of death for males in the general population (chi-square = 96.7, p < .001). These results suggest that clinical care for veterans diagnosed with chronic PTSD can be improved by a harm reduction approach, including attention to substance abuse relapse prevention and secondary prevention (HIV and hepatitis prevention, weapons safety; suicide prevention; and driving safety).

**PTSD and Substance Use in Inner-City Adolescent Girls**  
*Deborah Lipschitz, Department of Psychiatry, Yale University School of Medicine; Ann Rasmussen, Dept. of Psychiatry, Yale University School of Medicine; Walter Anyan, Dept. of Pediatrics, Yale University School of Medicine; Eileen Billingslea, Yale University School of Medicine; Steven Sourhwick, Dept. of Psychiatry, Yale University School of Medicine*

Purpose: Studies of combat veterans and traumatized adult civilians have found extremely high rates of comorbid substance use disorders and PTSD. The purpose of this study was to examine patterns of problematic substance use in relation to PTSD in inner-city adolescent girls. Method: 104 girls (Mean

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**Improving Early Interventions to Prevent Trauma-related Problems**

**Symposium (disaster) Grand Salon III, 3 (GB)**

*Endorsed by the Early Interventions Special Interest Group*

*Josef Ruzek, National Center for PTSD; Patricia Watson, National Center for PTSD*

This symposium presents results of a randomized controlled trial of two early cognitive-behavioral interventions and a large survey of the coping strategies reported by emergency services personnel. This work, together with a presentation on theoretical models of early intervention, is used to explore implications for prevention of trauma-related problems.

**Models of Early Intervention Following Trauma**

*Josef Ruzek, National Center for PTSD*

There are a variety of theoretical models that underlie common approaches to early intervention with trauma survivors. With some exceptions, most models have received only limited articulation or evaluation in the explicit context of early intervention. In this presentation, leading theoretical models that have implications for early intervention will be outlined, and an attempt will be made to expand and integrate current theoretical approaches. It will be argued that models of early intervention need to take into account the goals of intervention, the nature of hypothesized processes of development of PTSD and other negative consequences of trauma, the coping process, the temporal nature of the recovery process, specific intervention target behaviors and cognitions, and the post-trauma and service delivery environments. Several leading early interventions (e.g., debriefing, frontline military treatment, disaster mental health response, cognitive-behavioral packages) will be examined from the standpoint of an integrated model of early intervention, and current theory and research on risk and resilience factors will be used to derive a set of hypothetical principles of secondary prevention. The model and principles will be used to generate strategies for the improvement of secondary prevention methods and identify important theoretical and pragmatic questions for early intervention research.

**Coping Strategies Used by Emergency Services Personnel**

*Roderick Orner, Department of Clinical Psychology, Lincolnshire Healthcare Trust*

This presentation will review the results of a large survey of coping and adjustment strategies used by experienced emergency services personnel to modulate their emotional reactions evoked by major incidents and work-related trauma. Results indicate that help and support is first sought from peers and others with whom officers feel close. Involvement of professional care staff is typically not welcomed during the early post-trauma phase. Some significant differences were found between front line and second line emergency services responders, and one in five workers expressed a preference for not talking in detail about recent events in their early aftermath. Deliberate coping strategies typically involve confronting what has happened, rest and relaxation, re-establishing a sense of control and routines, finding release from somatosensory reactions to recent events, and waiting to see how reactions change and develop over time. The implications of these results for the planning and delivery of early intervention in the emergency services will be considered in detail.

**Enhancing Treatment Effectiveness for Acute Stress Disorder**

*Richard Bryant, University of New South Wales*

The majority of people who meet criteria for acute stress disorder (ASD) subsequently develop chronic posttraumatic stress disorder (PTSD). Although previous cognitive behavior therapy studies for ASD have demonstrated the efficacy of CBT in reducing subsequent PTSD, significant proportions of participants drop out of exposure-based therapy. This study aims to increase the effectiveness of treating ASD by evaluating non-exposure-based treatment. Specifically, ASD participants were randomly allocated to either (a) prolonged exposure (PE), (b) cognitive restructuring (CR), or (c) wait-list control (WL). Therapy comprised five weekly sessions of individual therapy. PE comprised education, imaginal exposure, in vivo exposure, and relapse

prevention. CR comprised education, identification of cognitive errors, daily monitoring of thoughts and affective states, and to modify thoughts by Socratic questioning, probabilistic reasoning, and evidence-based thinking. Manualized treatments were followed and independent fidelity checks were conducted. Blind assessments were conducted at 3 months, 6 months, and 12 month posttreatment. The study hypothesized that intent-to-treat analyses would indicate increased effectiveness for CR because of the reduced drop outs in the CR relative to the PE treatment conditions. Data are still being collected and 6-month follow-up data will be presented.

**Consequences of Violence and Trauma for Young African American Men**

**Symposium (culture) Grand Salon II, 3 (GB)**

**Featured Session**

*John Rich, Boston University School of Medicine*

Young African American men are at high risk for interpersonal violence and its consequences. This symposium will highlight quantitative and qualitative research about the epidemiology of violence and traumatic stress in this population, the unique social context in which these young men live and clinical models for addressing these problems.

**Black Male's Burden: Forms of Interpersonal Violence**

*La Mar Hasbrouck, Centers for Disease Control and Prevention*

**Purpose:** We describe the scope of interpersonal violence among black males, including homicide, assault victimization, and homicide by police. **Methods:** The National Vital Statistic System, Uniform Crime Reports, and the National Crime Victimization Survey data were used to examine homicide, homicide by police, and assault victimization, among black male victims 10 years and older from 1990 to 1999. Mortality rate ratios between blacks and whites (BW) were computed. **Findings:** Overall, age-adjusted homicide rates decreased by 96% from 1990 to 1999. Age-adjusted rates for homicide by police remained constant during the study period. BW rate ratios decreased from 6.8:1 in 1990 to 5.5:1 in 1999; and 3.7:1 in 1990 to 3.1:1 in 1999, for homicide and police homicide, respectfully. Black victimization rates have steadily declined since 1994. However, blacks continue to be violently victimized and robbed at the higher rates compared to whites. **Conclusions:** Despite the downward trends among black males for in homicide, assault victimization, and homicide by police, the black-white gap has remained constant during the study period. The disproportionate amount of trauma experienced by young black males from multiple types of interpersonal violence may help to explain higher rates of self-destructiveness, aggression, and substance abuse by blacks.

**Screening for Community Violence in Primary Care Settings**

*Gregory Leskin, National Center for PTSD; David Riggs, Center for Treatment and Study of Anxiety Disorders, University of Pennsylvania*

This project assessed histories of traumatic stressors and PTSD in young adult, African-American males at Boston Medical Center. Recent epidemiological studies of PTSD in outpatient medical settings have found high rates in both general community settings and "at risk" patients. Our primary objectives were to examine the frequency and intensity of community violence and the lingering psychological impact on crime victims. We assessed 30 young adult, African American males (mean age =25) to estimate the extent of lifetime exposure to community violence using the Survey for Exposure to Community Violence. The mean number of direct victimization experiences (e.g. being injured or having life threatened) for this group was 21.2 (SD=15.0). Using the PTSD Symptom Scale- Interview, about half (49%) of this group could be diagnosed with PTSD. Such findings shed light on the high rates of traumatic stress and PTSD in this "at risk" population and the need for routine screening and treatment using an integrated behavioral health model of care in primary care settings.

### The Experience of Violence for Young Black Men: Pathways to Reinjury

John Rich, Boston University School of Medicine; Courtney Grey, Boston University School of Medicine

Young African American men experience violent victimization at a high rate and the consequences of this trauma have implications for their risk of recurrent injury. The purpose of this project is to understand the lived experience of violence and symptoms of PTSD for young African American male victims of violence, using qualitative analysis of in-depth interviews. Open-ended interviews were conducted with 59 young African American men between the ages of 18 and 30 asking them to recount stories of their recent injury and their life experiences with violence. Interview data were taped, transcribed and analyzed for prominent themes. Using audiotaped excerpts, we will present an analysis that details the ways in which trauma affects the lives and behaviors of African American men. The presentation will focus on 3 areas: (1) symptoms of trauma, especially hypervigilance; (2) the “sucker phenomenon”—the pressure these men feel to retaliate in order to prove that they are not weak; and (3) the experiences that lead these young men to conclude that the police will not protect them. A conceptual model will shed light upon the pathways to recurrent violence and suggest strategies to decrease risk and improve the functioning of these young men.

### Child Abuse, Self-Representations, and Posttraumatic Stress

**Symposium (complex)**

**Grand Salon VIII, 3 (GB)**

Elizabeth Krause, Duke University; Christine Courtois, The CENTER: Posttraumatic Disorders Program, The Psychiatric Institute of Washington

Clinical studies indicate a link between child abuse and malignant thoughts and feelings about the self, discrepant self-models, and difficulties with self in relationships. This symposium presents research exploring these linkages and shares methods of operationalizing self-structure. Presentations also demonstrate associations between self-dysfunction and posttraumatic stress, revictimization, and personality disorders.

### Impact of Abuse on Children’s Self-Representation in Relationships

Catherine Ayoub, Harvard Graduate School of Education, Harvard University; Gabrielle Schlichtmann, Harvard Graduate School of Education, Harvard University; Erin O’Connor, Harvard Graduate School of Education, Harvard University

This presentation describes a multi-year study of the influence of abuse and neglect trauma on the social, emotional, and cognitive development of a sample of 85 young children. A partner project examined the parenting attitudes and beliefs, and psychosocial, family and life history of the children’s primary caregivers in an effort to understand the transgenerational effects of biology and child rearing on children’s self-development. Research findings delineate the varied developmental pathways of young maltreated and high-risk children, in the context of their psychological organization of self in relationships. In particular, the self-representations of maltreated versus high-risk children will be examined along a positive/negative dimension and in relation to emotional dissociation and subsequent coping responses to trauma. We will discuss three different pathways of development for these maltreated children, including presentation of primarily aggressive, controlling interactions, fearful, sad expressive styles and a masked, superficially positive interactive style. Differences in expressive style, self regulation, and thematic play in maltreated boys and girls will be described, as will the attachment and biological implications of their interactions. These diverse developmental pathways in young children will be related to the risk-potentiating and/or protective factors that are present in the face of child maltreatment in each family in the sample.

### Impact of Sexual Abuse on Self and Identity in Adolescents and Adults

Drew Westen, Center for Anxiety and Related Disorders and Dept. of Psychology, Boston University; Amy Heim, Dept. of Psychology, Boston University

Numerous studies have shown links between history of abuse and variables related to self, notably low self-esteem and disrupted sense of identity. This presentation attempts to examine two key issues surrounding this link: the role of other adverse events and family history in moderating or mediating the relation between abuse and aspects of self-experience; and patterned heterogeneity in response to abuse, such that different individuals respond in disparate, and often directly opposite, ways (e.g., becoming overcontrolled or undercontrolled across a range of life domains, such as affect and impulse regulation and sexuality). We report data from three studies bearing on the links between abuse and self-experience: a study of adults with personality disorders; a study of adolescents with personality disorders; and a study assessing aspects of personality and identity in a broad clinical example in which we oversampled for patients with an abuse history. The data suggest that, for both adolescents and adults, abuse experiences tend to have a substantial impact on self-representations, ability to establish an identity, sense of internal coherence, and self-esteem. Response to abuse, however, are highly variable, and other adverse events such as separations and disrupted attachment can produce similar effects.

### Impact of Childhood Abuse on Self-Discrepancies and Posttraumatic Stress

Elizabeth Krause, Duke University; Susan Roth, Duke University

Studies of the effects of childhood maltreatment have found a history of child abuse to be associated with negative self-representations and discrepancies between survivors’ current self-image and the person they would ideally be or ought to be. Self-discrepancy theory posits that actual-ideal self-discrepancy leads to emotional distress in the form of sadness and loss, while actual-ought self-discrepancy leads to anxiety-related distress (Higgins, 1987). Despite the prevalence of identity disruptions and depressive and anxiety symptoms among abuse survivors, few studies have examined self-discrepancy theory in relation to posttraumatic stress. The current study explored associations between child abuse history, self-discrepancies, and trauma recovery in a broad sample of women, including female undergraduates and hospital employees. Eighty women with and 100 women without a history of childhood physical or sexual abuse completed self-report measures of actual-ideal, actual-ought, and actual-undesired self-discrepancies. Further, participants who reported a history of abuse completed measures of PTSD symptoms and a broad range of stress responses or themes, including helplessness, loss, and self-blame. Compared to women without a history of abuse, abuse survivors reported more actual-ideal and actual-ought self-discrepancies. The actual-ideal self-discrepancy was significantly correlated with depression, anxiety, and the majority of trauma themes. Interestingly, the extent to which survivors viewed themselves as different from their undesired self was related to trauma resolution, but only for undergraduate survivors. Findings of in-depth interviews with a subset of survivors will also be discussed.

### Child Abuse: Self-Representations, Dissociation, and Attachment

Pamela Alexander, Albert Einstein Hospital Network; Mary Loos, Virginia Dept. of Mental Health, MR, and MSAS

Attachment theory is useful in exploring the relationship between childhood trauma, self-representations and other outcomes. According to Liotti (1992), disorganized attachment stemming from child abuse leads to the development of multiple incompatible models of the self, the sense of self as fundamentally flawed, and dissociation. Negative self-representations, dissociation, and unresolved attachment (the adult counterpart to disorganized attachment) are important partly in being potential mechanisms in the revictimization of abuse survivors. In a sample of high and low dissociators, high dissociators described significantly more negative characteristics of themselves as core to their personality and, in a Stroop task, exhibited significantly delayed reaction time on attachment anxiety stimuli only. Moreover, the number of core neg-

ative characteristics was directly associated with attachment-related anxiety but only in high dissociators. In a second sample consisting of battered women, the relationships among childhood trauma, core negative self-representations, dissociation, and unresolved attachment were explored in order to determine whether negative self-representations, dissociation, and unresolved attachment served as mediators between abuse history and the battered woman's stage of change (i.e., her tendency to either dismiss the current violence, view it as a cause for concern and/or take steps to escape the violence).

**Beyond PTSD: Community Recovery in New York City Post-9/11**

**Symposium (disaster) Grand Salon VI, 3 (GB)**  
**Featured Session**

*Jack Saul, New York University School of Medicine*

The challenge of trauma intervention following catastrophic disaster is to understand the multifaceted impacts of trauma and to tailor interventions to the targeted level. The presenters will describe a model that goes beyond clinical approaches and incorporates community organizing, social ritual, media, and art, in a comprehensive response to recovery.

**Survival, Recovery, and Preparedness: An Information Processing Model**

*Claude Chemtob, Mount Sinai School of Medicine*

This presentation will describe a model of trauma recovery that provides the context for mounting multi-level recovery interventions. The model extends the author's prior work with information processing models of PTSD and integrates it with his work implementing public health oriented approaches to post-disaster treatment. The author will propose that recovery is an information processing challenge whether it is at the level of an individual, a group, or a community. He will identify the challenges posed by recovery and specify the restrictions that a disaster causes. Moreover, the author will describe a model for supporting community recovery that implements these principles based on the proposition that catastrophic disasters require "giving away" trauma knowledge and creating community based trauma collaboratives. Examples of challenges implementing this approach will be described based on work in the NYC recovery. From the perspective of this approach, recovery and preparedness are an integrated activity that serves to support community cohesion in peace time and in times of national emergency.

**Collective Identity and Social Ritual: Using the System of the City**

*Mindy Fullilove, School of Public Health, Columbia University*

A city is a complex ecosystem, which includes a built environment that incorporates a wide area of common spaces, and a social environment within which the constituent parts are linked. A massive disaster to a city, such as the one suffered by New York City on 9/11, disrupts the physical and social organization of the city. Each of these disruptions acts independently to cause distress to individuals. The socio-spatial disruptions also act synergistically to aggravate individual level post-traumatic distress of all kinds. Trauma recovery at the level of the system of the city involves the careful crafting of "occasions" — the ceremonial gatherings of groups of people — that 1) build bridges across social and physical divides, 2) permit consciousness of the traumatic process, while avoiding false emotionality, and 3) support reconnection to people and place. This process involves multiple occasions, of different sizes, intents, and venues, that follow the arc of time away from the event in step with the arc of seasonal observations that are part of the pre-existing culture of the injured place. This presentation will describe the efforts of NYC RECOVERS to promote the creation of healing occasions throughout "2002: The Year of Recovery."

**Learning from Humanitarian Crises: Collective Recovery in Manhattan**

*Jack Saul, International Trauma Studies Program, New York*

The field of International Psychosocial Response to disaster and massive violence has much to contribute to an understanding of the social impact of the September 11 terrorist attacks and subsequent events in New York City. The author presents lessons learned from his experience in Kosovo and other international contexts that can be applied to promoting collective recovery in the his own Ground Zero community in lower Manhattan. Among the challenges faced have been — shifting of the dominant discourse from individual trauma to collective strengths and recovery, recognizing and supporting pre-existing capacities and resources in the community to address recovery needs, reducing social fragmentation, and enhancing parent and teacher skills to meet the needs of children. Residents have come together to develop community activities that acknowledge the impact of last year's events and provide spaces for public discourse about ongoing community needs, collective memory, and the community's emerging vision of recovery. The author will present examples of community recovery projects developed by residents in lower Manhattan ranging from public forums, community arts projects, oral history and visual archives, and internet based resources.

**Recall Bias In Retrospective Reports of Major Stressful Events**

**Symposium (assess) Kent A/B/C, 4 (HB)**

**Endorsed by Research Methodology Special Interest Group**

*J. Blake Turner, Columbia University*

Substantial evidence exists questioning the accuracy of retrospective reports of major stressful events. Furthermore, the bias resulting from recall errors generally favors the study hypotheses. This symposium, sponsored by the Research Methodology SIG, considers the nature and causes of recall errors and methods for improving recall in self-report data.

**Recall Bias In Checklist Reports of Exposure To War-Zone Stressors**

*Bruce Dohrenwend, N.Y. State Psychiatric Institute and Columbia University, Blake Turner, Columbia University*

In most research on the effects of war-zone stressors, the measurement of exposure has been based on veterans' recall in response to checklist-type items. Concern about the validity of such measures is not new (e.g., Green 1993, King and King 1991, Wolfe 1993). A study of Gulf War veterans conducted by Southwick et al. (1997) a few years ago suggested that there is, indeed, something to worry about. These investigators found a significant positive correlation between number of PTSD symptoms at a two-year follow-up and number of responses changed from "no" to "yes" on the second administration of their trauma questionnaire. At least three subsequent studies have used similar test-retest designs with samples of various veteran populations. The size of the effect reported varies. However, the magnitude of the bias cannot be assessed in any of these studies because none has an objective baseline measure of actual exposure. That systematic bias of this kind occurs at all between successive measures of post-exposure recall indicates that state dependent or mood congruent recall processes are operating. Use of measures of exposure that are susceptible to such processes compromises tests of dose/response relationships. We discuss how we are dealing with these measurement problems in our research with U.S. Vietnam veterans.

**Childhood Trauma and Adult Pain: Retrospective/Prospective Comparison**

*Karen Raphael, Univ. of Medicine and Dentistry of New Jersey; Cathy Widom, Univ. of Medicine and Dentistry of New Jersey*

Victims of childhood abuse have been viewed consistently to be at increased risk of developing medically unexplained pain in adulthood. Without exception, evidence for such a relationship derives from cross-sectional or case control studies in which childhood victimization status is assessed by retro-

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spective self-report. This presentation will illustrate how conclusions about the nature of the relationship between early trauma and later health can be biased by dependence upon retrospective self-reports of victimization. Using a prospective cohort design, cases of early childhood abuse or neglect documented between 1967 to 1971 (n=676) and demographically matched controls (n=520) were followed into young adulthood. The frequency of pain complaints reported at follow-up (1989-1995) was examined. Assessed prospectively, physically and sexually abused and neglected individuals were not at risk for increased pain symptoms. The odds of reporting one or more unexplained pain symptoms was not associated with any childhood victimization or specific types (i.e., sexual abuse, physical abuse, or neglect). In contrast, the odds of one or more unexplained pain symptoms was significantly associated with retrospective self-reports of all specific types of childhood victimization. Methodological implications for understanding the relation between childhood victimization and health in adulthood will be discussed.

**Treating Traumatic Bereavement in Children and Adolescents**

**Workshop (child) Laurel C/D, 4 (HB)**

Judith Cohen, Allegheny General Hospital; Anthony Mannarino, Allegheny General Hospital

Unfortunately many children lose a parent, sibling or other loved one due to traumatic events such as interpersonal violence, vehicular and other accidents, natural and man-made disasters, terrorist attacks and war. In children and adolescents, traumatic bereavement refers to a condition in which traumatic symptoms intrude on and interfere with the child's ability to negotiate the process of bereavement. For example, these children are typically unable to have positive memories of the deceased without these memories segueing into thoughts of the horrific way in which the person died. Both loss reminders and trauma reminders trigger intrusive thoughts, avoidance and hyperarousal symptoms which interfere with the child's ability to grieve. Treatment for this condition requires attention to both trauma and grief issues. Drs. Cohen and Mannarino will present an empirically based cognitive behavioral treatment model for traumatically bereaved children and their parents/primary caretakers. The trauma-focused portion of this model includes stress management training (relaxation, thought stopping, cognitive coping), gradual exposure (encouraging the child to describe the details of the traumatic event in increasing detail, along with associated thoughts, feelings and body sensations), cognitive processing (modifying inaccurate or unhelpful thoughts about the traumatic event), and joint child-parent sessions. The bereavement portion includes identifying and mourning what has been lost, resolving "unfinished business" with the deceased, preserving positive memories, transforming the relationship of the deceased to one of memory and reinvesting in present relationships, and making meaning of traumatic loss. Parallel parent sessions will be described for each component. Case examples will be used to illustrate each component of treatment.

**Treating Complex Trauma in Street Children**

**Workshop (child) Laurel A/B, 4 (HB)**

Angelea Panos, Intermountain Health Care; Jorge Villar Miguez, Junto Con Los Ninos; B. Hudnall Stamm, Institute of Rural Health, Idaho State University; Alison Anderson, Junto Con Los Ninos

This workshop will describe interventions for the treatment of complex trauma in street children. Reports on independent outcome studies will be given that demonstrate concrete long-term results. Children who live, or work on the streets are the most vulnerable and least protected members of society. It has been estimated that more than 100 million children around the world are struggling to survive under harsh and often exploitative conditions. Dire poverty creating economic need, violence and abuse in their homes, poor access to schools and commercial exploitation are underlying reasons why children take to the streets, where they easily fall victims to violence, sexual abuse, and crime. Trauma in many forms affects their lives, while the street living prevents healing opportunities such as being able to form emotional connections to caring adults, getting an education or developing their social abilities. Locked in this world of social exclusion they lack the

path to rejoin society and lead productive and meaningful lives. Family destabilization perpetuates the problem in younger siblings. A unique family strengthening intervention will be described that works to prevent younger siblings from becoming the next generation of street children.

**An Intervention for Integrating Communication and Conflict Skills**

**Workshop (practice) Dover A, 3 (GB)**

Sherry Riney, National Center for PTSD; Helena Young, National Center for PTSD

Survivors of traumatic experiences, particularly severe, chronic, or interpersonal traumas, often have trouble managing conflictual interpersonal interactions. Instinctive tendencies to defensively aggress when threatened, trauma-related anger and irritability, and poor social learning of appropriate interpersonal skills and conflict resolution may all contribute to difficulties with stressful interpersonal interactions. This workshop will review and demonstrate a multi-session group intervention aimed at improving communication and conflict resolution skills, taught at the National Center for PTSD Residential Rehabilitation Program. Based on Bower and Bower's techniques of assertive DESCription, and of Burns' techniques of recording dysfunctional thoughts and of disarming and empathizing, and active listening, the intervention addresses issues such as negative self-talk, isolation, inability to meet one's own needs, and difficulty resolving conflict. In the group, clients work on increasing their awareness of and interplay among their own affect, cognitions, behaviors, and attitudes and the effects of their behaviors on others. The intervention has been adapted for use with female trauma survivors, including those with severe personality disorders. In relation, the workshop will address modifications of the material to meet the exigencies posed by the National Center's Women's Program (e.g., limitation of critique, cheer-leading, boundary setting), the members of which often present with borderline features.

**Group Therapy for Male Trauma Survivors: Gender and Connection**

**Workshop (complex) Grand Salon I, 3 (GB)**

Phillip Brown, Victims of Violence Program at the Cambridge Health Alliance; Emily Schatzow, Victims of Violence Program at the Cambridge Health Alliance

At the Victims of Violence Program (VOV), trauma is viewed through a social and political lens. Treatment takes place in an urban, community-based clinic serving disenfranchised and marginalized populations. Group work is considered to be an integral component of trauma treatment as it helps survivors to understand their experience in the context of an environment that condones, and even encourages violence. During the past two decades, group services at VOV primarily targeted the needs of women. As the program evolved, it became apparent that the often-invisible male survivors of childhood trauma could benefit from treatment which would honor their unique experience. One treatment modality for this population is a time-limited psychotherapy group for men, led by men, which explores the sequelae of abuse and its influence on self-esteem, masculine identity, and sexuality. This group is often the first place for isolated, shame-prone male survivors to become part of a community that fosters safe relationships and an environment for healing. There will be a special emphasis on how relational issues are addressed in same gender versus mixed gender trauma groups. Using didactic and case material, this presentation will explore the formation, structure, process, and content of this group model.

**Psychological Intervention with Civilian Terror Victims**

**Case (practice) Falkland, 4 (HB)**

Sara Freedman, Hadassah University Hospital, Israel; Rhonda Adessky, Hadassah University Hospital, Israel

Treatment of Post-traumatic Stress Disorder using Cognitive Behavior Therapy is well established as an effective intervention. It has been used for PTSD patients following a number of different trauma types. The aim of this presentation is to examine CBT treatment of a series of civilians, who were involved in terrorist attacks, and whose treatment took place during a period

of on-going regional conflict. All patients were treated on an out-patient basis at a Psychiatric Clinic. Patients include men and women, both Jewish and Arab civilians, ranging in age from 18 to 50. Patients were either witnesses to, or physically injured during, terrorist bombs or shootings. This presentation will focus on the clinical issues raised: the suitability of CBT; the treatment implications of on-going conflict; and the impact of cognitive therapy. The conclusions that can be drawn from these cases include the therapeutic importance of case conceptualization, and the changes to standard protocols that are needed in treating patients during exceptional circumstances.

**10:00 a.m.—11:30 a.m.**

**Plenary Session**

**Trauma and Reconciliation:  
The Case of Northern Ireland**

**Plenary** **Grand Salon VI, 3 (GB)**

*Oscar Daly, MD, Consultant Psychiatrist, Lagan Valley Hospital, Lisburn, Northern Ireland; Alan McBride, Maura Kiely, Malcom New, Joseph Doherty, Alistar Little*

This plenary panel will address aspects of the civil disturbances in Northern Ireland, known there as “The Troubles,” which began in 1969. In particular, the issue as to who is, or should be considered to be, a victim will be addressed, as will the controversial topic of whether victims should be considered in a hierarchical fashion. That is, are persons such as “innocent” bystanders and members of the security forces more deserving of the term “victim” and the associated right to treatment and compensation than others such as members of paramilitary groupings and those with particular political affiliations? Each participant will present a short paper and there will then be an open discussion. The participants include Alan McBride and Maura Kiely, who are bereaved relations of people killed by paramilitary members; Malcolm New, an ex-British soldier who served several tours in Northern Ireland and is suffering from PTSD; and Joseph Doherty and Alistair Little, who have served terms of imprisonment for paramilitary killings.

**1:00 p.m.—2:15 p.m.**

**Poster Presenters of Track 9, Disaster, Mass Trauma, Prevention, and Early Intervention, and Track 11, Miscellaneous will be available to discuss their posters.**

**Grand Salon V, 3 (GB)**

**Trauma-Related Research Priorities and Funding Programs: National Institute on Drug Abuse**

**Forum (clin res)** **Grand Salon VII, 3 (GB)**

*Timothy Condon, National Institute on Drug Abuse, NIH; Paul Schnur, Division of Neuroscience and Behavioral Research, National Institute on Drug Abuse, NIH; Cece McNamara, Division of Treatment Research and Development, National Institute on Drug Abuse*

The National Institute on Drug Abuse (NIDA) is one of the National Institutes of Health and is responsible for conducting over 85% of the world’s research on drug abuse and addiction. NIDA maintains a robust research portfolio investigating the overall role that trauma and stress can play in initiation of drug use and relapse to drug use, as well as the intensification of resulting symptoms. This includes research to develop better ways to teach drug abusers how to cope with stress, craving, and drug-associated stimuli as well as research to help determine what makes some individuals more or less vulnerable to abuse and addiction, particularly after experiencing a traumatic event. This forum will provide an overview of NIDA’s breadth of research related to trauma and substance abuse, provide specific examples of current research projects underway, and highlight new research areas in need of further investigation, particularly in the wake of events such as September 11th.

**Brief Dynamic Psychotherapy (BDP) for Traumatic Grief**

**Master Clinician Session (practice)** **Grand Salon VI, 3 (GB)**

*Charles Marmar, University of California, San Francisco and Department of Veterans Affairs Medical Center, San Francisco*

This role-play session will illustrate a brief form of psychodynamic psychotherapy with a client who has unresolved traumatic loss of a parent in childhood complicated by a terrorist attack in which both her own life was in danger and she also lost a close relationship (the same “client” as the other master clinician sessions). I will illustrate key components of this treatment: establishing a therapeutic alliance, taking a history of the event and the relationship to those lost in both the childhood and adult traumatic events, identifying core relationship conflicts related to wishes, fears and compromises, the ways in which the recent adult traumatic loss reactivates aspects of the childhood trauma, including views of self and other as dangerously weak or strong, the emergence of the core conflict in the here and now of the relationship with the therapist, the resonance of traumatic loss for the therapist including the risk for activation of the therapist’s own core conflicts, and the intensification and opportunities for mastery of the core conflict during termination.

**Human Rights and Complex Trauma:  
From the Global to the Individual**

**Panel Discussions (complex)** **Grand Salon VIII, 3 (GB)**

**Endorsed by the Human Rights and Social Policy Special Interest Group**

*Eric Aronson, Amnesty International USA; Morton Winston, The College of New Jersey; Karen Hanscom, Advocates for Survivors of Trauma and Torture; Judy Okawa, Program for Survivors of Torture and Severe Trauma at Center for Multicultural Human Services*

Clinicians have realized that symptoms of complex psychological trauma are common sequelae of serious human rights abuses (such as rape, torture and other forms of political violence). However, many trauma researchers and clinicians may focus on these sequelae and pay scant attention to the larger context of trauma events themselves. This presentation explores the continuum of complex trauma, from global, sociopolitical issues to individual experience. Human rights are a public health concern, directly related to

Friday: 1:00 p.m.—2:15 p.m.

psychological trauma. Human rights advocacy and education are therefore essential to the primary prevention of trauma, particularly complex trauma. The presentation details several approaches to advocacy, in connection with specific violations of human rights; some success stories are included. Also included is a model of education that addresses the social, political and economic context of human rights. At the level of individual-in-community, political empowerment and self-esteem are discovered to be central to the healing of Guatemalan survivors of severe human rights abuses. Finally, the individual experience of complex trauma will be discussed, with a description of the work of the National Consortium of Torture Treatment Programs to empower survivors, help them recover their dignity, and to raise awareness in the U.S. of human rights violations.

**Post-traumatic Stress and Psychological Comorbidity Following Cancer**

**Symposium (clin res) Dover B/C, 3 (GB)**

*Maria Kangas, School of Psychology, University of New South Wales, Australia*

Since DSM-IV, a spate of research has focused on the utility of PTSD following cancer. This symposium presents three studies, which examined the prevalence and predictors of post-traumatic stress symptoms in mothers of pediatric BMT recipients, women with metastatic breast cancer and their spouses, and head and neck cancer patients.

**PTSD in Mothers of Children Undergoing BMT**

*Sharon Manne, Fox Chase Cancer Center; Katherine Du Hamel, Ruttenberg Cancer Center, Mt. Sinai School of Medicine; Jane Austin, Ruttenberg Cancer Center; Jamie Ostroff, Memorial Sloan Kettering Cancer Center; Susan Parsons, Dana Farber Cancer Institute; Richard Martini, Northwestern University Medical Center-Children's Hospital; Sharon Williams, Stanford University Hospital-Packard Childrens Hospital; Laura Mee, Emory University Medical Center; Sandra Sexson, Emory University Medical Center; Lisa Wu, Ruttenberg Cancer Center*

Pediatric Bone Marrow Transplantation (BMT) can have a profound long-term psychological impact on mothers who watch their children undergo this risky procedure. Mothers may experience anxiety and depressive symptoms as well as posttraumatic stress disorder. This study adopted a prospective, longitudinal design to identify mothers who develop PTSD in the 18 month time period following their child's BMT. Mothers were administered the SCID- PTSD-NP version six months after the BMT and again 18 months after the BMT, as well as self-report measures of anxiety and depressive symptoms. Mothers also completed measures of anxiety, depression and multiple other psychosocial instruments at the time of the BMT. To date, 81 mothers have completed the six month and 45 mothers have completed the 18 month SCID interview. Results indicate that 15% of mothers merited a diagnosis of PTSD six months after their child's BMT, and 10% of mothers merited a PTSD diagnosis 18 months after their child's BMT. Mothers who reported more anxiety and depressive symptoms at the time of the BMT were significantly more likely to have PTSD at the follow ups. These findings are discussed in terms of prevalence and predictors of PTSD among persons witnessing a traumatic life event, as well as implications for potential interventions for mothers who are at risk.

**Correlates, Predictors, and Course of Trauma Symptoms in Cancer**

*Lisa Butler, Stanford University School of Medicine; Xin-Hua Chen, Stanford University School of Medicine; Karin Calde, Stanford University School of Medicine; David Spiegel, Stanford University School of Medicine*

This presentation will provide an overview of baseline and follow-up data on trauma symptoms from a large randomized trial that includes 125 women with metastatic breast cancer patients and 50 of their spouses or partners. Findings indicate that a significant minority of patients and their spouses experience cancer-related trauma symptoms and that symptom levels are uncorrelated within couples. Among the patients, symptoms are associated with past life stress and aversive social support and are correlated with overall distress. In general, patient symptoms tend to decline over time, but a "spike" in symptoms may occur in the period prior to death. Among spouses, post-loss trauma symptoms are significantly predicted by baseline (pre-loss)

symptoms, perceived stress, and the degree of impact they anticipate regarding the potential future loss of their wives/partners. In this study we have also found that group support (weekly for patients, monthly for spouses) appears to reduce trauma symptoms, particularly avoidance symptoms, over 12 months. Implications of these findings will be discussed.

**Incidence, Course and Predictors of ASD and PTSD Following Cancer**

*Maria Kangas, University of New South Wales, Australia; Richard Bryant, University of New South Wales, Australia*

The utility of the ASD diagnosis in predicting PTSD following cancer has yet to be empirically validated. This study adopted a prospective, longitudinal design to identify cancer patients who are at risk of developing PTSD by assessing them for ASD within four weeks of diagnosis (T1), and re-assessing them at six- (T2) and twelve- (T3) months. At T1, 82 newly diagnosed head, neck and lung cancer patients were administered the Acute Stress Disorder Interview, SCID DSM-IV, and several self-report measures. ASD was diagnosed in 28% of the sample, and 48% of the ASD group met criteria for Major Depression post-cancer diagnosis. The ASD group obtained significantly elevated scores on attribution, coping, social support and quality of life measures. ASD was also associated with chronic/premorbidity anxiety disorders. At T2 and T3, participants were administered the CAPS-1. To date, N=51 patients have been assessed at T2, and 25.5% (61.5% ASD) met criteria for PTSD. The majority of patients with PTSD at T2 continue to be symptomatic at T3. These findings are discussed in terms of the applicability and predictors of ASD and PTSD following cancer, as well as the utility of early identification of patients who may require psychological intervention.

**Psychological Functioning/Adaptation in Child and Adolescent Refugees**

**Symposium (child) Dover A, 3 (GB)**

*Wanda Grant Knight, Boston University School of Medicine; Terence Keane, Boston VA Hospital, Boston University School of Medicine*

The symposium participants are from sites in the National Child Traumatic Stress Network that work with child and adolescent refugees. Presenters will describe research and clinical work with these populations examining traumatic symptomatology and coping, mental health interventions, and community outreach efforts. Descriptions of the effectiveness and practicality of these interventions also will be discussed.

**National Child Traumatic Stress Network Projects on Refugee Children**

*Robert DeMartino, Center for Mental Health Services/Substance Abuse and Mental Health Services Administration*

This presentation will begin by providing a brief overview of the impetus for developing the National Child Traumatic Stress Network (NCTSN) to evaluate and address the needs of children and adolescents who have experienced traumatic events. During this presentation special attention will be paid to several sites within the NCTSN engaged in work with child and adolescent refugee populations (Boston University Medical Center, the Solace Program at Safe Horizon-Saint Vincent's Child Trauma Care Continuum, and the Family Trauma Treatment Program). This presenter will introduce these sites and participate in discussion of the relevance of these sites' work for contributing to the mission of the NCTSN, and enhancing our understanding of the impact of war, displacement, and resettlement on children's and adolescents' traumatic stress responses.

**Psychosocial Interventions with Refugee Communities**

*Ernest Duff, Safe Horizon/Solace*

Safe Horizon is the nation's leading victim assistance organization, and is a participant in the National Child Traumatic Stress Initiative. Solace is the torture survivors program within Safe Horizon. Solace has developed an approach to treatment that is de-centralized and psychosocial, which emphasizes dialogue with refugee communities about their needs, and involvement of refugees as

participants in the processes of healing. The needs of refugee children are of paramount concern for newly arrived refugee communities. Solace has worked extensively with West African refugee children within community structures on Staten Island, including former child soldiers and amputees from the war in Sierra Leone. This work has been in partnership with refugees themselves, members of the mainstream community, and with other Safe Horizon programs. This ongoing work, utilizing expressive therapeutic approaches, including visual and dramatic arts, is reaching multiple groups of children and adolescents throughout the West African communities, and the link between the communities and clinical providers continues to be the psychosocial, intensive case management approach of Solace staff. The relationship of the Solace psychosocial model to the successful creation of bridges that reach underserved refugee children in a marginalized community will be described, and the connection of this model to an ongoing ethnographic evaluation approach will be reviewed.

#### Psychological Functioning of Child and Adolescent Refugees

Dennis Hunt, *Center for Multicultural Human Services*; Marion Chew, *Center for Multicultural Human Services*

This component of the symposium will provide a brief overview of the work done by the Center for Multicultural Human Services with children and families who have been traumatized by war and displacement. Emphasis will be placed on identifying strategies used to engage the Sierra Leonean community in Northern Virginia and on approaches used to help children and adolescents in this community heal from the complex trauma they have experienced.

#### Psychological Functioning in Resettled Unaccompanied Sudanese Minors

Wanda Grant Knight, *Boston University School of Medicine*; Paul Geltman, *Boston University School of Medicine*; Janice Goodman, *Boston College*; Stuart Lustig, *Boston University School of Medicine*

Over the past few years the plight of world citizens experiencing displacement as a result of international conflict and war has come to the forefront of national attention. Estimates of the number of those displaced by such occurrences range from 20-22 million worldwide, with approximately half of this number representing children and adolescents. These displaced citizens, or refugees, frequently experience torture, loss, and hardship in the process of leaving their homelands. Increasingly there has been attention to the effect of war and displacement on adult refugee populations, with a particular focus on psychological adaptation in these groups. Unfortunately, to date, there has not been much investigation of psychological functioning in younger refugees, especially those who go through this process without parental supports, often referred to as unaccompanied minors. Thus little is known about the impact of war, displacement, and resettlement on these groups. This presentation describes a large-scale national survey with one group of unaccompanied refugee minors, resettled Sudanese adolescents. This presentation will report on the experience of traumatic symptoms and coping abilities among these teens with an emphasis on the cross-cultural factors impacting on their functioning and adaptation to life in the United States.

### The Developmental Psychobiology of Childhood Trauma: Part I

Symposium (child)

Laurel A/B, 4 (HB)

#### Featured Session

#### Endorsed by the Gender and Trauma Special Interest Group

Karestan Koenen, *Boston Medical Center and National Center for PTSD*; Frank Putnam, *Children's Medical Center, Washington, D.C.*

Over 1.5 million American children are victims of maltreatment each year. Recent advances in developmental psychobiology and neuroscience suggest that early maltreatment produces enduring negative effects on children's psychobiological and brain development. This symposium is Part I of II presenting recent findings in this area. Clinical implications will be discussed.

#### Does Mother's Violence History Affect Her Present Parenting?

Daniel Schechter, *Columbia University College of Physicians and Surgeons*; Charles Zeanah, *Tulane University School of Medicine*; Susan Brunelli, *Columbia University College of Physicians and Surgeons*; Michael Meyers, *Columbia University College of Physicians and Surgeons*; Susan Coates, *Columbia University College of Physicians and Surgeons*; Patricia Baca, *Columbia University College of Physicians and Surgeons*; Myron Hofer, *Columbia University College of Physicians and Surgeons*

Objective: While maternal trauma history, attachment, and psychopathology have been hypothesized as risk factors for intergenerational transmission of violent trauma, mechanisms by which such factors interact to carry effects remain unclear. Methods: Subjects were 41 referred mothers (ages 18-45 years) and children (ages 8-50 months). Mothers had histories of physical and/or sexual abuse and/or other interpersonal violence exposure. Subjects participated in 2 videotaped sessions including: a clinical interview assessing maternal trauma history, mental states, and perceptions (Time 1), as well as a mother-child interaction procedure with separation-reunions (Time 2). Perception was assessed by coding attributions toward the child along dimensions of negativity and distortion. Data were analyzed using bivariate correlations and multiple regression. Results: Maternal trauma history severity was significantly associated with the degree of posttraumatic stress symptoms (PTSS) but not depression or attributional quality. Greater maternal depression comorbid with PTSS was associated with more negative and distorted attributions toward the child. Conclusions: Degree of PTSS especially when comorbid with depression likely affects maternal perception. The effects of violent trauma history severity on maternal perception may well be mediated through psychopathology. We are currently conducting data analyses to relate these findings to maternal interactive behavior and physiology.

#### The Neurobiology of Child Abuse

Martin Teicher, *Department of Psychiatry, Harvard Medical School and McLean Hospital*

Severe early stress and maltreatment produces a cascade of events that has the potential to alter brain development. The first stage of the cascade involves the stress-induced programming of the glucocorticoid, noradrenergic and vasopressin-oxytocin stress response systems to augment stress responses. These neurohumors then produce effects on neurogenesis, synaptic overproduction and pruning, and myelination during specific sensitive periods. Major consequences include: reduced size of the mid-portion of the corpus callosum; attenuated development of the left neocortex, hippocampus and amygdala along with abnormal frontotemporal electrical activity; and reduced functional activity of the cerebellar vermis. These alterations, in turn, provide the neurobiological framework through which early abuse increases the risk of developing PTSD, depression, symptoms of attention-deficit/hyperactivity, borderline personality disorder, dissociative identity disorder, and substance abuse. Through this perspective we can better appreciate that the biological underpinnings of psychiatric disorders are not necessarily genetic, and that early experience can exert dramatic effects on neural circuitry, structure and function.

Friday: 1:00 p.m.-2:15 p.m.

**Cerebellar Volumes in Pediatric Maltreatment-related PTSD and GAD**

Michael DeBellis, Duke University; M. Keshavan, Western Psychiatric Institute and Clinic; S. Beers, Western Psychiatric Institute and Clinic; N. Ryan, Western Psychiatric Institute and Clinic

Background: The cerebellum is involved in the integration of higher cognitive function, demonstrates dramatic growth during childhood and adolescence, and is uniquely susceptible to environmental influences. Methods: In this study, 58 psychotropic naive children and adolescents with maltreatment-related PTSD, 13 non-traumatized children and adolescents with generalized anxiety disorder (GAD) and 98 age and sex matched healthy control children and adolescents underwent comprehensive clinical assessments and anatomical MRI brain scans. Results: Compared with controls, subjects with maltreatment-related PTSD had smaller cerebellar volumes than GAD and healthy controls even after controlling for cerebral volume ( $F=6.3, p=.002$ ) and cerebral volume, full scale IQ and socioeconomic status ( $F=6.7, p<.002$ ). No differences were observed between GAD and control subjects. Adjusted cerebellar volumes positively correlated with the age of onset of the maltreatment experience that lead to PTSD ( $r=.4, p<.002$ ). No sex by group interactions was seen. Conclusions: These data provide further evidence to suggest that maltreatment-related PTSD in childhood is associated with adverse brain development. The cognitive significance of these findings remains to be elucidated.

**The Influence of Domestic Violence on Children’s IQ: A Twin Study**

Karestan Koenen, Boston Medical Center and National Center for PTSD; Shaun Purcell, Institute of Psychiatry, London; Terrie Moffitt, Institute of Psychiatry, London and University of Wisconsin; Avshalom Caspi, Institute of Psychiatry, London and University of Wisconsin

Recent research suggests exposure to chronic trauma in childhood may have enduring negative effects on children’s brain development. These results suggest that this exposure will be associated with deficits in performance on cognitive tasks, however, the relationship between exposure to trauma and children’s performance on standard neuropsychological tasks has received scant attention. The present study examines the association between exposure to domestic violence and IQ in an epidemiological sample of 1116 5-year-old monozygotic and dizygotic twin pairs from the United Kingdom (response rate 93%). Mothers were interviewed regarding their experience of domestic violence over the past 5 years. Twins’ IQ was assessed by interviewers blind to mothers’ experience of domestic violence. Structural equation modeling was used to examine whether exposure to domestic violence was associated with lower IQ after accounting for the influence of genetic and other shared environmental factors on IQ. Results indicate that exposure to domestic violence is associated with lower IQ in a dose-response relationship. This finding persists after accounting for the influence of genetic and other shared environmental factors on the variance in IQ. Moreover, at high levels of domestic violence, the influence of other shared environmental factors (e.g. parental education) on variance in IQ is greatly reduced.

**Study of Identical Twins Discordant for Combat Exposure in Vietnam**

Symposium (biomed)

Grand Salon IV, 3 (GB)

**Featured Session**

Roger Pitman, Department of Psychiatry, Harvard Medical School

Studying identical twins provides a powerful means of resolving the origin of comorbid psychiatric, psychological, and physiological abnormalities in PTSD. This presentation will convey results of a study of identical twins discordant for combat in Vietnam. Results of ongoing analyses may be presented in addition to those described in the two formal presentations.

**Physiologic Responses to Tones in Twins Discordant for Combat Exposure**

Scott Orr, VA Research Service, Harvard Medical School; Linda Metzger, VA Research Service, Harvard Medical School; Natasha Lasko, VA Research Service, Harvard Medical School; Frank Hu, Harvard University School of Public Health; Michael Macklin, VA Research Service, Ariele Shalev, Hadassah University Hospital/Hebrew University Medical School, Israel; Roger Pitman, Department of Psychiatry, Harvard Medical School

Larger heart rate (HR) responses to sudden, loud (startling) tones are a highly replicated psychophysiological marker for PTSD. This abnormality may be a pre-trauma vulnerability factor, i.e., it may have been present prior to the event’s occurrence and increased the individual’s likelihood of developing PTSD upon traumatic exposure. Alternately, it may be an acquired PTSD sign, i.e., it may have developed after the traumatic exposure, along with the PTSD. Studying identical twins discordant for traumatic exposure offers an opportunity to resolve these competing origins. In this study, subjects included pairs of Vietnam combat veterans and their non-combat-exposed identical twins. Combat veterans were diagnosed as current PTSD ( $n=50$ ) or non-PTSD (i.e., never had,  $n=53$ ). Subjects listened to a series of fifteen sudden, loud tone presentations while HR, skin conductance, and orbicularis oculi electromyogram were measured. Average HR responses to the tones were larger in Vietnam combat veterans with PTSD than in the other three groups ( $p<.0001$ ). Significant group differences were not found for the other physiologic measures. These results suggest that larger heart rate responses to sudden, loud tones represent an acquired sign of PTSD, rather than a familial vulnerability factor.

**Twin Study of the Origin of Psychiatric Comorbidity in PTSD**

Natasha Lasko, VA Research Service, Harvard Medical School; Alexander McFarlane, University of Adelaide, Australia; Scott Orr, VA Research Service, Harvard Medical School; Linda Metzger, VA Research Service, Harvard Medical School; William True, VA Medical Center, St. Louis University School of Public Health; Michael Lyons, Boston University School of Medicine, VA Medical Center; Jack Goldberg, Vietnam Era Twin Registry, VA Medical Center, University of Washington; Seth Eisen, Washington University School of Medicine; Ming Tsuang, Department of Psychiatry, Harvard Medical School; Roger Pitman, Department of Psychiatry, Harvard Medical School

Chronic PTSD has high comorbidity. Proneness to mental disorders may confer vulnerability to PTSD. Alternately, the traumatic event’s impact may extend beyond PTSD to cause other mental disorders. This study attempted to clarify the origin of comorbid disorders in PTSD. Subjects included pairs of combat-exposed (Ex) Vietnam veterans and their combat-unexposed (Ux) identical twins. Pairs were classified as current PTSD (P+,  $n=50$ ) or non-PTSD (i.e., never had, P-,  $n=54$ ) based upon the Clinician-Administered PTSD Scale results in the combat twin. All subjects underwent the Structured Clinical Interview for DSM-IV and Symptom Check List-90-Revised (SCL-90-R). Group means (SD) on the SCL-90-R Global Symptom Inventory were: ExP+ 1.8 (0.8), ExP- 0.6 (0.6), UxP+ 0.6 (0.7), UxP- 0.4 (0.4). The Diagnosis x Exposure interaction was significant ( $p<.0001$ ); adjusted for the interaction, neither main effect was significant. ExP+ subjects had more affective disorder than the three other groups ( $p<.001$ ). There was significantly more non-combat-related PTSD in UxP+ than in UxP- subjects ( $p=.01$ ). These results suggest that comorbid psychopathology in PTSD results from the traumatic event. Judging from their identical twins, PTSD veterans, had they not gone to combat, would have been at significantly higher risk for non-combat-related PTSD but not for other mental disorders.

**The ABCs of CBT with Traumatized Children and Their Families**

Workshop (child)

Laurel C/D, 4 (HB)

Anthony Mannarino, Allegheny General Hospital; Judith Cohen, Allegheny General Hospital; Esther Deblinger, University of Medicine and Denistry of New Jersey

Trauma-focused cognitive behavior therapy (CBT) has been empirically demonstrated to be an efficacious treatment for traumatized children and their families. This workshop will present the basic interventions that are included in this model of treatment which include stress inoculation tech-

niques, psychoeducation, gradual exposure interventions, and cognitive processing. There will be a particular emphasis on how these treatment strategies can be implemented with children of different age groups. Additionally, there will be a focus on the importance of including the child's caretakers in any treatment that is provided and how CBT interventions for the caretakers parallel those used with the children. A summary of recent research findings which support trauma-focused CBT with this population will also be presented.

**Reducing Clinician's Fears of Using Established CSExposure Techniques**

**Workshop (practice) Grand Salon III, 3 (GB)**

Donald Levis, Binghamton University; Patricia Rourke, Binghamton University

Although behavioral and cognitive-behavioral therapy approaches enjoy the greatest levels of empirical support, we contend that many clinical training programs fail to adequately emphasize the basic learning principles that underlie these techniques and provide a critical basis for understanding the development and elimination of symptoms of psychopathology. Similarly, there is a notable failure by many programs to provide systematic training in dealing with the high levels of emotional distress common in some clinical populations (e.g., trauma survivors). This, we argue, has led to reluctance on the part of many clinicians to utilize some empirically supported exposure therapies, such as implosive therapy, in the treatment of trauma survivors for fear that they will either inadvertently exacerbate clinical symptomatology and/or become vicariously traumatized themselves. The major purposes of this workshop are to: (1) provide clinicians with a detailed review of some of the most well-supported learning principles that underlie the use of exposure therapies, demonstrating how knowledge of these principles can improve the efficacy of therapy and (2) provide exposure, via videotaped segments of actual therapy sessions, to high levels of client affect with the goals of (a) habituating clinicians to high levels of distress, (b) illustrating the clients' rapid recovery following such exposure, and (c) suggesting techniques to minimize therapists' stress when using these procedures.

**The ABCs of IRBs for Trauma-related Research**

**Workshop (misc) Grand Salon II, 3 (GB)**

Elana Newman, University of Tulsa; Adil Shamoo, Department of Biochemistry and Molecular Biology, University of Maryland, Baltimore; Judith Brooks, Office for Human Research Protections, Department of Health and Human Services

This workshop will focus on the nuts and bolts of applying ethical decision making to trauma-related research and submitting a clear human subjects review application. Dr. Shamoo will present an overview of the key issues to consider with respect to ethical issues and the process of ethical decision-making. A member of the education staff from the Office of Human Research Protections Department of Health and Human Services will describe the nuts and bolts of completing a strong IRB application, focusing on the 45CFR. Dr. Newman will review pertinent research regarding what we know about participants' responses to research and specific issues related to trauma. The last portion of the seminar will involve breaking up into groups and practicing ethical decision-making with respect to 2 proposed trauma-related research projects.

**Groups for War Veterans: Models, Staging, and Meeting Challenges**

**Workshop (practice) Grand Salon I, 3 (GB)**

Melissa Wattenberg, VA-Boston Healthcare—Outpatient Clinic, Tufts; Shirley Glynn, UCLA-West Los Angeles VAMC; William Unger, Brown University/Providence VAMC; Barbara Niles, National Center for PTSD, VA Boston Healthcare System

While group therapy is widely used for combat survivors, data supporting specific group models have been relatively scant. This workshop offers intermediate to advanced interventions in two effective models of group treatment for chronic combat-related PTSD: Trauma Focus, a skills-building and exposure-based model incorporating psychoeducation, coping-skills train-

ing, exposure therapy, cognitive restructuring, and relapse prevention in a developmental perspective; and Present-Centered, a supportive/process-group approach informed by schema theory for PTSD, targeting symptoms which disrupt orientation to current life, and using group interaction as the basis for reframing trauma-based assumptions and behaviors, with psychoeducation as needed. The essential elements of each treatment will be presented, in the context of data from a 10-site randomized VA trial supporting their efficacy. Emphasis will be placed on implementing and maintaining active treatment in the face of challenges regularly encountered with combat survivors (such as avoidance, trauma-based attitudes and beliefs, common comorbidities (e.g., substance abuse, mood disorders, personality disorders)). The Workshop will cover: recommended staging of interventions; eliciting consistent attendance and participation; responding to trust and compliance issues; managing dissociation, re-experiencing, and intense hyperarousal; dealing with multiple traumatizations; and addressing family issues affecting treatment. Didactic materials, demonstrations, and role-play exercises will be utilized.

**PTSD Psychopharmacology Primer for Clinical Practice**

**Workshop (practice) Kent A/B/C, 4 (HB)**

Linda Nagy, Dartmouth Medical School; Randall Marshall, Columbia University; Claudia Zayfert, Dartmouth

Non-physicians and beginning psychiatrists can find pharmacotherapy in patients with PTSD somewhat bewildering, and there are few empirical guidelines for how best to implement combined interventions. Challenging factors include the complexity of PTSD, a paucity of controlled medication studies in PTSD, common comorbid psychiatric and medical conditions, split psychotherapy/pharmacotherapy arrangements, and typical characteristics of patients with PTSD, such as problems with trust. This workshop is intended to provide basic information to help guide pharmacotherapy. The range of medications currently used and target symptoms will be discussed to illustrate some basic concepts. Suggestions will be offered regarding how to make an effective referral, facilitate communication, integrate treatments in a synergistic way, and avoid common pitfalls. Speakers will address situations bridging medication and psychotherapy encountered in clinical practice.

**Child Holocaust Survivors' Apparently Normal Lives: At What Cost?**

**Case (complex) Galena, 4 (HB)**

Yvonne Tauber, AMCHA and The Israeli Center for the Treatment of Psychotrauma; Danny Brom, The Israel Center for the Treatment of Psychotrauma; Motti Cohen, ELAH, Herzog Hospital, Outpatient Clinic, Jerusalem

Child survivors of the Holocaust have gone through complex sequences of trauma, loss and recovery from early childhood on. Many of them have adapted to life very successfully. A small minority show psychopathology that impedes their daily functioning. We will present findings of research and case material of individual and group therapy from our clinical practice in Israel, in order to show the price many survivors have been paying for an apparently normal life. Our main contention is that the manifestations of unprocessed traumatic memories are manifold and not necessarily readily recognizable as such. Clinicians might, therefore, accept the strong parts of the survivors and be insufficiently aware of the suffering hidden behind often isolated (presenting) symptoms. These clients are not necessarily aware either of the connections between specific (current) difficulties and their severe trauma histories. The recent stresses and trauma in Israel may increase the tendency of survivors to hold on to "the (apparently) normal". Therapists are also inclined to reinforce the coping side of their clients and collude with the clients in the denial of problems. Implications for clinical work with severely traumatized, who succeed to live "normal lives" will be discussed.

## Complex PTSD as a Clinical Pathway for Violent Behavior

Case (practice)

Falkland, 4 (HB)

Ange Puig, Puig Associates; Maureen Santina, Associates in Forensic Psychology

Studies suggest there is underdiagnosis of Posttraumatic Stress Disorder in children. Children involved in the criminal justice system are frequently discovered to have untreated psychiatric disorders. The view that children can be diagnosed with PTSD is relatively recent. Questions have been raised whether current PTSD diagnostic criteria adequately capture the range of traumatic experiences and effects in children's lives. Children may be exposed to intrafamilial violence, neglect, sexual exploitation, and psychological maltreatment. Research indicates that earlier onset of trauma produces greater depth of traumatic damage and potential for lifelong adverse effects. The term complex PTSD describes the multi-systemic consequences of early chronic trauma. These children are frequently misdiagnosed with disruptive behavior disorders without appreciation for the role of trauma in the development of aggressive and self-destructive behaviors. A case will be presented of a young adult male suffering from complex posttraumatic symptomatology who committed a homicide subsequent to a recent acute traumatic stressor. The interplay of pre-existing symptomatology and subsequent exacerbation will be discussed as factors in producing aggressive behavior. Clinicians should consider the role of complex PTSD in development of dyscontrol as part of forensic assessments of violent behavior. Earlier identification and intervention may improve approaches to youth violence.

2:30 p.m.—3:45 p.m.

## Disaster, Terrorism, and Trauma Programming at SAMHSA/CMHS

Forum (disaster)

Galena, 4 (HB)

Seth Hassett, Emergency Services and Disaster Relief Branch, Center for Mental Health Services, SAMHSA; Robert DeMartino, Programs in Trauma and Terrorism, Center for Mental Health Services, SAMHSA; Fran H. Norris, Department of Psychology, Georgia State University

The Substance Abuse and Mental Health Services Administration (SAMHSA) is a federal agency within the U.S. Department of Health and Human Services whose mission is to improve the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses. SAMHSA is comprised of three Centers including the Center for Mental Health Services (CMHS), which heads efforts to speed the application of mental health treatments for people with mental illnesses. One of the areas of special focus for CMHS is disaster mental health and emergency services. This panel will describe the disaster and terrorism-related programs and priorities at CMHS. We will also summarize the results of a CMHS-sponsored empirical review of the disaster mental health-related research that has been published over the past two decades. This summary will include what is known about the potential range, magnitude, and duration of a disaster's effects on the mental health of the stricken community, and the experiential, demographic, and psychosocial factors that influence who within that community is most likely to be adversely affected. An interactive discussion will then focus on the implications of CMHS programming and the summary of the research base for disaster mental health practice and research.

## National Institutes of Health Research Funding and Applications

Forum (clin res)

Grand Salon VII, 3 (GB)

Cindy Miner, Office of Science Policy and Communications, National Institute on Drug Abuse; Teri Levitin, Office of Extramural Affairs, National Institute on Drug Abuse; Cheryl Boyce, National Institutes of Health

This workshop is designed to orient junior as well as seasoned investigators unfamiliar with the National Institutes of Health (NIH) to the grant process. The critical elements of grant writing and the NIH review and funding processes will be discussed, including changes involving budgets and IRB approval that make it easier to prepare applications. In addition, participants will become familiar with grant opportunities currently available at the National Institute on Drug Abuse (NIDA) and the National Institute on Mental Health (NIMH), as well as how to access the most up-to-date information on new opportunities as they arise. Staff members from NIDA and NIMH will discuss grant mechanisms available to fund research including those mechanisms designed for newer investigators. Time will also be available for questions and discussion.

## Compassion Fatigue in Israeli Professional Caretakers

Panel Discussions (complex)

Falkland, 4 (HB)

Bruce Lackie, Walden University; Rony Berger, Natal Center-Tel Aviv; Danny Brom, Center for Psychotrauma; Barbara Hanoch, Hadassah Hospital, Israel; Yvonne Tauber, AMCHA and the Israeli Center for Psychotrauma

This panel discussion will present the on-going experience of professional caretakers who are responsible for addressing complex trauma issues in Israel, even as they are embedded within the conflict themselves. The focus on compassion fatigue presents powerful testimony to the realities of sustained care and the challenges of promoting hope in the face of an escalating vortex of violence.

**Prevention of Intergenerational Transmission of Traumatic Effects**

**Symposium (disaster) Grand Salon III, 3 (GB)**

**Featured Session**

*Charles Portney, UCLA Medical School, Dept. of Psychiatry*

Dr. Armsworth will present the results of a study of four generations of 45 women who experienced childhood incest. Dr. Elmore will provide an overview of a program to prevent hate, violence and ultimately genocide. Dr. Trickett will discuss childrearing attitudes and practices of mothers of physically or sexually abused children.

**Generational Complex Trauma: Systemic Treatment and Prevention**

*Mary Armsworth, University of Houston*

The “cascading” of complex trauma through four generations of 45 women who experienced childhood incest is examined using multigenerational genograms, narrative data from semi-structured interviews, and demographic information. The current study sought to further understand attitudes toward parenting and other pregnancy choices in the sample, and to examine the frequency and type of abuse and trauma in participants’ families. Data were subjected to qualitative and descriptive analyses with salient themes and patterns indicating the presence of complex trauma in the majority of generational reports. Patterns that emerged included multigenerational losses and absence of mourning; relational disconnections with incapacitation in self and other protection; severe alterations in affect regulation, and permeation of generations with fear, isolation, betrayal, and silence. An analysis of resilient behavior represented is also discussed. Results of this preliminary study are used as the basis for suggestions for (1) future research and methodological issues; (2) development and targeting prevention efforts at various systemic levels, including parent education and social skills development programs; and (3) the use of a variety of intervention strategies in treatment of individuals and family systems, including genograms as metaphors, trauma narrative reconstruction, verbalizing and disclosing the unspeakable, and identification of markers of trauma integration.

**Preventing Hate and Genocide in the Next Generation**

*Diane Elmore, Honolulu VA Medical Center/National Center for PTSD*

Evidence suggests that human beings are not born prejudice or bigoted, but rather learn these attitudes and behaviors from those around them (ADL, 1999). As attitudes and behaviors are learned, they can also be unlearned. Although many efforts are being made to focus on interventions in this area which promote more positive outcomes in the next generation, little is known about the efficacy of such programs. The purpose of the current presentation will be to provide an overview of an empirically evaluated program which uses the historical trauma of the Holocaust to promote prejudice awareness and teach the consequences of apathy in order to prevent hate, violence, and ultimately, genocide. One hundred forty nine high school students participated in the six week prevention/intervention program and completed a series of quantitative as well as qualitative assessment tools at three points in time (pretest, posttest, and follow-up). The findings of the current investigation indicated that this prevention/intervention program did in fact have a positive impact on participants’ knowledge, attitudes, and behaviors both immediately after training and following a four-month delay. The current investigation lends support to the notion that prevention/intervention programs can help to foster peace and humanity in the next generation.

**Childrearing Attitudes and Practices of Parents of Abused Children**

*Penelope Trickett, University of Southern California*

This presentation focuses on the childrearing attitudes and reported practices of parents of children who were physically or sexually abused. Findings from two studies will be reported. The first was a cross-sectional study of the impact of physical abuse on 4 to 10-year-old boys and girls. The abusive parents (mothers and fathers) took part in this study and reported on many facets of their child-rearing attitudes and practices, especially use of different

forms of discipline; perceptions of the child and/or childrearing as enjoyable or difficult; and satisfaction with their child (see, for example, Trickett and Kuczynski, 1986; Trickett and Susman, 1988; 1989). The second study is a longitudinal study of the psychobiological impact of familial sexual abuse on girls. At the beginning of this study, the sample consisted of 6 to 16-year-old sexually abused girls and their mothers (or other non-abusing caretaker) and a demographically similar comparison group (see, e.g., Trickett and Putnam, 1993). Many of the same measures of childrearing attitudes and practices (as used in the physical abuse study described above) were included in this study (see, e.g., Trickett, Everett, and Putnam, 1995), thus allowing for comparisons between families in homes with physical abuse and those with sexual abuse.

**Child Traumatic Stress in Medical Settings**

**Symposium (child) Dover A, 3 (GB)**

*Glenn Saxe, Boston University School of Medicine/National Child Traumatic Stress Network; Robert Pynoos, UCLA/National Child Traumatic Stress Network*

This symposium reviews the medical setting as a location of traumatic stress assessment and intervention for children. In particular we present studies of children with burns, traffic accidents, organ transplantation, and cancer. These studies are discussed in terms of an emerging area of expertise on traumatic stress in medical settings.

**ASD and PTSD in Children Hospitalized with Burns**

*Glenn Saxe, Boston University School of Medicine/National Child Traumatic Stress Network; Frederick Stoddard, Shriners Burns Hospitals/Massachusetts General Hospital; Neharika Chawla, Boston University School of Medicine/National Child Traumatic Stress Network; Carlos Lopez, Boston University School of Medicine/National Child Traumatic Stress Network; Robert Sheriden, Shriners Burns Hospitals/Massachusetts General Hospital; Lynda King, National Center for PTSD/VA Healthcare New England/Boston University; Daniel King, National Center for PTSD/VA Healthcare New England/Boston University*

This presentation describes an ongoing longitudinal study of children hospitalized with an acute burn. The main aims of this study are to determine the relationship between the DSM-IV diagnoses of ASD and PTSD and to determine risk factors for the development of ASD and PTSD. Sixty-one children, between the ages of 7 and 18, admitted to Shriners Burns Hospital for an acute burn were evaluated within 2 weeks of their burn for the presence of ASD using a clinical interview aided by the Child PTSD Reaction Index. Children were reassessed 3 months following discharge for the presence of PTSD. Thirty-one percent of children with burns met DSM-IV criteria for ASD. At 3-month follow-up 22% of children met criteria for PTSD. A diagnosis of ASD yielded a threefold risk for PTSD at follow-up. The dissociative symptoms of ASD (criterion B), in particular, predicted PTSD. The dose of morphine administered during the hospitalization was significantly related to symptom attenuation over three months. Multiple regression analysis demonstrated that variables of acute dissociation, early life behavioral dysregulation, and life stress in the year prior to the burn were the strongest predictors of PTSD symptoms.

**Acute and Post-traumatic Stress After Pediatric Traffic-related Injury**

*Nancy Kassam-Adams, Children’s Hospital of Philadelphia; Flora Winston, Children’s Hospital of Philadelphia and University of Pennsylvania; Chiara Baxt, Children’s Hospital of Philadelphia*

Traffic crashes are one of the most common causes of unintentional pediatric injury, with nearly one million children per year in the US receiving medical treatment for injuries sustained as pedestrians, bicyclists, or passengers. This presentation will report on a prospective study of post-traumatic stress among 250 children (age 8 to 17) and their parents, enrolled at a large urban pediatric hospital following admission for a traffic-related injury. Children and parents were assessed within 1 month of injury and again 4 to 8 months post-injury. At follow-up, 20% of children and 10% of their parents exhibited clinically significant post-traumatic symptoms, with 6% of children and 9% of parents meeting symptom criteria for PTSD diagnosis. Predictors of child PTSD symptom severity include subjective sense of life threat, exposure to frightening sights or sounds, separation from parents, the child’s experience of pain

in the acute post-injury period, child ASD severity within the first month post-injury, and parental acute distress. Parent responses appear to be key in children's emotional recovery from injury. A model for the interaction between child and parent responses to traumatic injury, including coping, social support, and the coping assistance provided to children by parents and peers, will be presented.

### Assessment of Posttraumatic Symptoms in Medically Ill Children

*Eyal Shemesh, Mt. Sinai Hospital; Jeffrey Newcorn, Child and Adolescent Psychiatry, Mount Sinai Medical Center; Abraham Bartell, Children After Trauma Care and Health Program, Mount Sinai Medical Center; Rachel Yehuda, Division of Traumatic Stress Studies, Mount Sinai Medical Center*

Symptoms of Posttraumatic Stress Disorder (PTSD) have been described in medically ill patients. They may be a consequence of trauma related to the disease process (i.e., a surgical procedure) or unrelated (i.e., a history of abuse in a child who is ill). PTSD symptoms may interact with the child's medical illness and lead to its exacerbation via several potential mechanisms. For example, we have previously reported an association between symptoms of PTSD and nonadherence to medications in pediatric transplant recipients. In this presentation, we will describe findings from completed or ongoing studies that examine the interaction between traumatization and medical illness in children who are being treated in pediatric care settings. For example, in a survey of pediatric Emergency Room (ER) patients, medical-illness related traumatic exposure was reported by 40% of 62 participants and PTSD was related to increased ER utilization ( $p=0.02$ , controlling for age and sex); in an ongoing study of medically-ill children, above-threshold PTSD was diagnosed in 15% of 66 patients who were evaluated thus far. In a survey of pediatric transplant recipients, a history of abuse was associated with death due to nonadherence. The potential implications of these findings will conclude this presentation.

### Worst Moments: Adolescents' Descriptions of Traumatic Medical Events

*Margaret Stuber, University of California at Los Angeles; Lisa Mintzer, University of California at Los Angeles; Gregory Young, University of California at Los Angeles*

Although research has recently demonstrated that survivors of life-threatening medical illness report PTSD symptoms, little is known about what aspects of these experiences constitutes the traumatic event. As part of a larger study, 96 adolescent heart, liver or kidney transplant recipients were asked to describe the "worst moment" of their transplant experience and when that moment occurred. The majority of adolescents described worst moments during the period of transplant hospitalization. Most events related to threats to body integrity, rather than life threat. These findings suggest that a medical procedure such as organ transplantation can itself be experienced as traumatic or the "worst moment" despite the life-threatening condition it serves to alleviate. Understanding the worst moment of medical trauma helps to clarify potential traumatic memories to target for intervention, and suggests a possible entry point for prevention. Further analyses are underway on the relationship between the identified traumatic event and PTSD symptoms and other psychosocial variables. Comparisons will also be made to a similar set of data collected on a sample of adolescent cancer patients.

### The Developmental Psychobiology of Childhood Trauma: Part II

**Symposium (child)**

**Laurel A/B, 4 (HB)**

**Endorsed by the Gender and Trauma Special Interest Group**

*Karestan Koenen, Boston Medical Center and National Center for PTSD; Michael Debellis, Duke University*

The development of human psychobiological and brain systems continues through young adulthood. Recent advances in developmental psychobiology and neuroscience suggest that exposure to trauma during these critical developmental periods can have lasting effects on these systems. This symposium is Part II of II presenting recent findings on the developmental psychobiology of trauma. Clinical implications will be discussed.

### Trauma and the Development of Metacognitive Skills in Young Children

*Clancy Blair, Pennsylvania State University*

The paper will focus on the role of negative emotionality and stress response in young children. It will explore the ways in which negative emotionality and stress response may be associated with problems with the development of higher order thinking skills in young children generally referred to as executive or metacognitive skills. Specifically, a developmental neurobiological model will be presented in which negative emotionality and stress responses have direct effects on neural plasticity related to the frontal cortex. Implications of this developmental model for risk for psychopathology following traumatic stress will be considered. Children's self-regulatory abilities in a variety of contexts such as in the adjustment to daycare or the transition to school will also be discussed. Particular attention will be paid to interactions between frontal functioning and the reactivity of the autonomic nervous system. Data linking cardiac vagal tone, an index of autonomic regulation of the heart, negative emotionality, and the adjustment to preschool among children from low income backgrounds will be presented. Implications for the prevention of learning and behavior problems will be discussed.

### Initial Hormonal Predictors of Psychopathology in Child Trauma Victims

*Douglas Delahanty, Department of Psychology, Kent State University; Nicole Nugent, Kent State University; Norman Christopher, Kent State University*

Although equivocal, biological research on adult PTSD victims has suggested that PTSD is associated with lower than normal cortisol and higher than normal catecholamine levels. The few studies examining children have suggested the opposite: that children with PTSD have significantly higher cortisol levels than similarly exposed children without PTSD. However, these studies have examined children years after the traumatic event(s). The present ongoing study examines the relationship between initial hormone levels and subsequent PTSD and depression symptoms. Participants are victims between the ages of 8-18 who are admitted to the trauma unit of a local hospital. Twelve-hour urine samples (for catecholamine and cortisol analyses) are collected beginning at hospital admission, and six weeks later, the CAPS-CA and Reynolds Depression Scales are administered in the patient's home. Preliminary results reveal that initial urinary cortisol, norepinephrine (NE), and epinephrine (E) levels are positively correlated with subsequent depressive symptomatology ( $r_s=.83, .92$ , and  $.96$ , respectively; all  $p_s<.01$ ). Similarly, PTSD symptoms are also positively correlated with initial cortisol, NE and E ( $r_s=.72, .83, .78$ , respectively;  $p_s = .04-.07$ ). Results suggest that children at risk for developing PTSD and depression may respond with elevated hormone levels in the immediate aftermath of a traumatic event.

### Terrorism's Lasting Biological Effects on Direct Victims and Offspring

*Phebe Tucker, Department of Psychiatry, University of Oklahoma; Betty Pfefferbaum, Department of Psychiatry, University of Oklahoma; Carol North, Washington University School of Medicine; Akim Hossain, Department of Psychiatry, University of Oklahoma; Dorothy Wyatt, Department of Psychiatry, University of Oklahoma; Sridevi Nagumalli, Department of Psychiatry, University of Oklahoma; Adrian Kent, Department of Psychiatry, University of Oklahoma*

A pilot study assessed adults highly exposed to the 1995 Oklahoma City bombing and their children 6 1/2 to 7 years later for emotional symptoms and autonomic reactivity to trauma reminders to determine long-term consequences of terrorism. 11 direct victims (in the Federal Building during the blast or injured close by) and their 15 children, who were aged 6-14 years at the time of the disaster, were assessed for PTSD (IES) and depression (BDI) symptoms. Autonomic reactivity was measured through heart rate and blood pressure responses to a 4-minute trauma interview. Adult victims' measures were compared to 13 mentally healthy (SCID-IV) adult controls who had experienced different trauma. Parent-child dyads were compared to determine whether vicarious child victims' emotional and physiological symptoms resembled their parents'. Direct victims of terrorism had significantly higher emotional symptomatology and autonomic reactivity 6-7 years later com-

pared to adults exposed to other types of trauma, suggesting enduring sensitization to trauma in these individuals. Direct victims' children had increased physiological reactivity at levels of their parents and significantly higher than trauma controls. Findings suggest that intense exposure to terrorism causes long-term sequelae, and that children of direct victims may also have long-lasting consequences from exposure to their parents' suffering.

**Contextual, Therapeutic, and Forensic Paradigms for Complex Trauma**

**Symposium (complex) Grand Salon VI, 3 (GB)**

*Laura Brown, Washington School of Professional Psychology-Argosy University Seattle*

This symposium will address three issues in the understanding of complex trauma. We will examine the context in which complex trauma occurs; psychotherapeutic treatment strategies; and forensic issues for evaluators in complex trauma cases.

**The Context of Complex Trauma: A Contextual Model of Complex PTSD**

*Steven Gold, Center for Psychological Studies, Nova Southeastern University*

The "Complex PTSD" construct evolved largely from recognition that trauma was prevalent in the histories of many clients whose difficulties included but extended well beyond those comprising Posttraumatic Stress Disorder. These clients—with a broad range of symptoms spanning syndromes such as dissociative, personality, addictive and somatoform disorders—were frequently viewed as having extremely poor prognoses. It was assumed that trauma-focused treatment would be considerably more effective for them than interventions that did not take their trauma histories into account. However, clinical observation and empirical research evidence suggest that there are often factors in the backgrounds of Complex PTSD clients in addition to trauma that contribute appreciably to their difficulties. Individuals with extensive trauma histories are frequently reared in interpersonal contexts that model ineffective coping strategies, fail to adequately transmit capacities needed for adaptive functioning, and foster extreme interpersonal dependency and unassertiveness. A contextual perspective underscores the need to focus treatment on helping these clients develop adaptive capacities that, if never previously established, will not be established via trauma-focused intervention alone. Implications of contextual theory for treatment of Complex PTSD will be considered.

**Treatment Approaches for PTSD**

*Christine Courtois, The Center: Post Traumatic Disorders Program*

This presentation will provide an overview of treatment modalities that are now available and recommended for different types of posttraumatic reactions and disorders. The presenter will draw from the authoritative literature and research and from a review of the available consensus guidelines in support of the various types of interventions. The underlying philosophy of this presentation, in keeping with the available literature and research findings, is that most treatment for posttrauma adaptations should be tailored to the needs of the individual and should be multimodal. Since posttrauma adaptations are highly variable and constitute a complex biopsychosocial stress response, so too should interventions be variable and biopsychosocial in order to provide holistic and comprehensive treatment.

**Forensic Assessment of Complex Post-Trauma in Civil Cases**

*Laura Brown, Washington School of Professional Psychology, Argosy University*

This presentation will focus on the application of knowledge of complex posttraumatic states in the context of civil litigation. A multi-method strategy for the assessment of complex post traumatic symptoms will be discussed, and a paradigm for writing and testifying about plaintiffs with both complex trauma histories, and complex trauma symptoms, will be described. The influence of such variables as gender, race, culture, and social class on the process of forensic assessment of complex post-traumatic states will be explored.

**Sleep, Dreams, and PTSD**

**Symposium (biomed) Grand Salon IV, 3 (GB)**

*Thomas Mellman, Dartmouth Medical School, Department of Psychiatry*

Much of the documentation of traumatic nightmares has been anecdotal and there is uncertainty regarding the nature of sleep disturbance with PTSD. The symposium brings together new research findings that relate dream content themes and REM sleep patterns to trauma exposure and development of PTSD, and nightmare physiology to fear response mechanisms.

**Contextualized Images in Dreams Before and After September 11, 2001**

*Ernest Hartmann, Tufts University School of Medicine, Newton-Wellesley Hospital*

A contextualizing image (CI) is a powerful central image in a dream which can be seen as picturing, or providing a picture-context for, the dominant emotion of the dreamer. Thus the paradigmatic dream, "I was overwhelmed by a tidal wave," contextualizes the dominant emotion of fear/terror or helplessness. Dreams following trauma have been shown to have more powerful imagery in periods after trauma than at other times. This study examined the question of whether CIs were more prevalent and more intense in dreams following the tragedy of September 11, than before. Dreams were collected for both time periods and scored blindly according to an established protocol. Results upheld the hypotheses.

**Relationships of Dream Content to Recent Trauma and PTSD**

*Wilfred Pigeon, Dartmouth School of Medicine, Department of Psychiatry; Thomas Mellman, Dartmouth School of Medicine*

Trauma-related nightmares are considered an important feature of PTSD and have been associated with the early development of the disorder (Mellman et al., 2001). In this study we provide a more comprehensive analysis of dream content from recently traumatized participants, compare content to normative dream samples, and further evaluate relationships to the development of PTSD. Dreams were recorded using morning diaries from patients hospitalized for injuries related to accidents or impersonal assaults. Patients meeting criteria were initially evaluated within two weeks of injury and PTSD status was determined by structured interview, two months post-injury. Dreams were coded using an established system and compared to previously collected normative data (Domhoff and Schneider, '98) and between participants who were positive and negative for PTSD. Forty-five dreams from 25 participants were analyzed. Dreams of trauma patients had significantly more physical aggression although the dreamers were less often the aggressor, and more content related to anatomy. There was less sexuality, friendliness and good fortune. Within the injured patients, those who developed PTSD symptoms had more ratings for bodily misfortune and negative emotions. These data suggest that dream content is influenced by recent experience of threat and injury and may be revealing of emotional processing relevant to the development of PTSD.

**The Psychophysiology of PTSD Nightmares**

*Steven Woodward, VA Palo Alto Health Care System*

Many obstacles arise in the scientific study of trauma-related nightmares and their definitive characterization in neurobiological terms may be far off. Nevertheless, a picture is emerging from studies comparing persons with and without nightmares, and from observations of a small number of "symptomatic arousals" using ambulatory sleep recording. This picture owes much, as well, to the advances that have been made in the understanding of central sleep and fear mechanisms and their potential interactions. It has been demonstrated, for example, that the amygdala and bed nucleus modulate the arousability of pontine nuclei involved in the regulation of REM sleep. Data will be reviewed indicating that trauma-related nightmares may reflect excess central fear system activation during sleep. The findings associated with nightmare complaint, which includes increased vigilance, REM-associated awakenings, reduced whole-body movements, and accelerated respiration, appears to reflect a fear system mode which Lang et al (2000) have termed "defensive immobility", and which contrasts both behaviorally and psychophysio-

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logically with the familiar “fight/flight” pattern of fear behavior. Interestingly, the imposition of “defensive immobility” upon normal sleep may be associated with objective modifications, such as movement suppression, suggestive of improved sleep. Implications for clinical trials aimed at ameliorating trauma-related sleep disturbances will be discussed.

### REM Sleep and the Early Development of PTSD

*Thomas Mellman, Dartmouth School of Medicine; Victoria Bustamante, University of Miami, Department of Psychiatry and Behavioral Sciences; Wilfred Pigeon, Dartmouth School of Medicine, Dept. Psychiatry; Bruce Nolan, University of Miami, Department of Neurology*

Arousal regulation and memory consolidation appear to be important in determining the development of PTSD, and both are functions of sleep. Sleep findings from chronic PTSD are complex and somewhat contradictory, and data from the acute phase are quite limited. The aim of the present study was to obtain polysomnographic recordings (PSGs) during an acute period following life-threatening experiences and injury, and to relate measures of sleep duration and maintenance, and the timing, intensity and continuity of rapid eye movement (REM) sleep to the early development of PTSD. Twenty-one injured subjects meeting study criteria received at least one PSG close to the time of medical/surgical stabilization and within a month of injury. PTSD symptoms were assessed concurrently and 6 weeks later. Sleep measures were compared between injured subjects with and without significant PTSD symptoms at follow-up, and 10 healthy, non-injured controls, and were also correlated with PTSD severity. There was more wake time after the onset of sleep in injured, trauma exposed patients compared to non-injured controls. Development of PTSD symptoms was associated with shorter average duration of REM sleep prior to a stage change and greater number of REM periods. The development of PTSD symptoms following traumatic injury was associated with a more fragmented pattern of REM sleep.

### Psychological Reactions to the 9/11 Terrorist Attacks

**Symposium (disaster)**

**Kent A/B/C, 4 (HB)**

*Grant Marshall, RAND*

Recent empirical research examining the impact of the September 11, 2001, terrorist attacks on subsequent psychosocial outcomes will be presented. Findings relevant to the impact on New York City, Washington, D.C., and nation-wide reactions will be described. Insights gleaned using different data collection modalities and design protocols will be highlighted.

### Distress and Resiliency in Coping with the Tragedy of 9/11

*Lisa Butler, Stanford University School of Medicine; Jay Azarow, Stanford University School of Medicine; Juliette Desjardins, Stanford University School of Medicine; Andrew Hastings, Stanford University School of Medicine; Cheryl Koopman, Stanford University School of Medicine; David Spiegel, Stanford University School of Medicine*

Following the tragic events of 9/11/01, Americans struggled to come to terms with what they had experienced. For some, exposure to the event was immediate and terrifying, involving threat to self or loved ones. For others, exposure was less direct yet still troubling, due to relentless media presentation of footage of the attacks themselves and of their aftermath. In the face of these experiences, Americans responded in many ways, including engaging in general coping strategies (such as positive reframing, substance use, behavioral disengagement, etc.) and employing behaviors specific to coping with the event (such as donating money, displaying an American flag, avoiding media coverage, etc.). In this presentation we will introduce data collected as part of an Internet-based prospective study of how over 7000 Americans and others have coped with the stress of the terrorist attacks. (Six-month follow-up data collection is currently underway.) Analyses will include an examination of (1) the relationship of event exposure (type, degree) to coping strategies (general, 9/11-specific) adopted at baseline, and (2) which coping strategies predicted adjustment at 6-month follow-up, including both distress (trauma symptoms, general distress) and resiliency (psychological and social well-being) outcomes. The implications of the findings for early intervention will be discussed.

### A National Longitudinal Study of Responses to the 9/11 Attacks

*Alison Holman, University of California, Irvine; Daniel McIntosh, University of Denver; Michael Poulin, University of California; Virginia Gil-Rivas, University of California; Roxanne Silver, University of California*

Over the past six months, our research team has successfully completed a longitudinal investigation of early emotional, cognitive, and social responses to the terrorist attacks of September 11, 2001. We collected data from a national random sample of 1382 individuals two months post 9/11 using an anonymous Web-based survey methodology. Pre-September 11th health and health care utilization data are available on most of these individuals. Nine hundred thirty three subjects had completed stress and coping measures 9-14 days after the attacks, and an additional 449 were over-sampled from each of 4 cities that had experienced community-based trauma (New York, NY, Oklahoma City, OK, Littleton, CO, and Miami, FL). A 6-month follow-up of respondents is currently underway. The purpose of this project is: 1) To investigate the psychological and social processes that help explain individual differences in response to the 9/11 terrorist attacks; 2) To identify early predictors of long-term adjustment to the 9/11 attacks; 3) To compare responses to the 9/11 events among individuals who have previously experienced a traumatic event (either personally or in their communities) with those who have not previously encountered trauma; and 4) To investigate the psychological and social processes that help explain the variability in responses to stressful life events more generally.

### Findings from the National Survey of American's Reactions to 9/11

*William Schlenger, Research Triangle Institute; Juesta Caddell, Research Triangle Institute; Lori Ebert, Research Triangle Institute; B. Kathleen Jordan, Research Triangle Institute; Kathryn Rourke, Research Triangle Institute; David Wilson, Research Triangle Institute; Lisa Thalji, Research Triangle Institute; J. Michael Dennis, Knowledge Networks; John Fairbank, Duke University Medical School; Richard Kulka, Research Triangle Institute*

This presentation will summarize findings from the National Survey of Americans' Reactions to September 11 (N-SARS) with respect to posttraumatic stress disorder (PTSD) and post-exposure alcohol use. N-SARS surveyed a national sample of adults during the second month after the terrorist attacks. The sample was selected from the Knowledge Networks Web-Enabled Panel, a probability-based research panel with about 60,000 enrolled households nationwide, and included oversamples of the New York and Washington, DC, metropolitan areas. The survey assessed direct and indirect exposures to the September 11 attacks, and included the PTSD Checklist (PCL) and the 18-item version of the Brief Symptom Inventory (BSI), and a total of 2,273 adults participated. Findings indicated that the PTSD prevalence (assessed via the PCL) was elevated in the New York, but not the Washington, metropolitan area relative to the rest of the U.S. Findings from the BSI, however, indicate that all across the country to overall levels of clinically significant psychological distress were within normal limits. Findings concerning post-exposure alcohol use suggest a decrease in alcohol use in the month following the attacks.

### Posttraumatic Stress Disorder and Depression in NYC After 9/11

*Sandro Galea, Center for Urban Epidemiologic Studies, New York Academy of Medicine; Jennifer Ahern, Center for Urban Epidemiologic Studies, New York Academy of Medicine; Heidi Resnick, National Crime Victims Research and Treatment Center, Medical U of SC; Dean Kilpatrick, National Crime Victims Research and Treatment Center, Medical U of SC; David Vlahov Center for Urban Epidemiologic Studies, New York Academy of Medicine*

Background: We assessed the prevalence and correlates of acute post-traumatic stress disorder (PTSD) and depression (MD) in residents of New York City (NYC) 1, 4, and 6 months after the September 11 attacks. Methods: In each survey we used random digit dialing to contact a representative sample of adults in the progressively larger portions of the NYC metropolitan area. Participants were interviewed about personal characteristics, exposure to the events of September 11, PTSD and MD symptoms. Results: We interviewed 988 and 2,001 adults in the first two surveys respectively and target recruitment in the ongoing third survey is 2,670. The past month prevalence of PTSD and MD were 8.8% (95% CI=7.0-10.8) and 9.7% (95% CI=4.4-7.7) respectively 1 month after and 3.8% (95% CI=2.8-4.7) and 3.5% (95% CI=2.6-

4.4) 4 months after September 11. Event-experiences including peri-traumatic panic were predictive of PTSD and losses (e.g., loss of a relative) and low social support were predictive of MD in multivariable models. Conclusions: There was a substantial burden of acute PTSD and MD in Manhattan after the September 11 attacks; one third to one half of those with PTSD and MD at the diagnostic level improved in the first 4 months after the attacks.

### Complex Trauma in Family Systems

**Symposium (complex) Grand Salon VIII, 3 (GB)**

Linda Williams, Wellesley College

A complex web of trauma may occur in family systems. Parents of traumatized children often have their own complex trauma histories. Intrafamilial violence occurs in the context of violence over the lifespan, in multiple relationships, and in the community. We present and discuss the complexities of trauma in 500 families.

### Functioning of Children with Complex Victimization Histories

Benjamin Saunders, Medical University of South Carolina; Linda Williams, Wellesley College; Rochelle Hanson, Medical University of South Carolina; Daniel Smith, Medical University of South Carolina

Past research has indicated that experiencing multiple types of victimizations in childhood is associated with several serious mental health problems. However, most research has been conducted retrospectively with clinical or community samples of adults. Relatively little research has directly examined children with complex victimization histories. Consequently, there is little information on what specific victim and victimization characteristics increase the likelihood of initial problems among children with complicated victimization histories. This paper will examine associations between victimization characteristics and mental health problems among children with more or less complex victimization histories. Data will be used from the Navy Family Study, a longitudinal study of 543 Navy families recently reported to authorities for child sexual abuse, child physical abuse, or domestic violence. Using structured in-person interviews, the 196 child participants (age 7-17 years) were assessed for a history of sexual assault, physical assault, physical abuse by a parent, witnessing community violence, and witnessing domestic violence. Diagnostic interviews for PTSD and major depression (both from the National Survey of Adolescents) were conducted, and the TSCC, CDI, and RCMAAS were administered. Approximately, 70% of these children reported experiencing two or more types of violence, and 20% described a history of four or five types. As expected, children reporting having experienced two or more types of violence scored significantly higher on measures of PTSD symptoms, depression, and anxiety. Further analysis revealed significant interactions, however. For example, teenage females were more likely to have complex victimization histories compared to males of any age or younger females (an average of 2.94 victimization types vs. 1.92 for other gender-age groups), and were more likely to have been sexually assaulted. Also, 34% of teen girls in these families met diagnostic criteria for PTSD compared to 5% for the other gender-age groups. Similar results were found for depression and anxiety symptoms. Results suggested that among children there is a compound interaction between age, gender, victimization history, and victimization characteristics in statistical associations with PTSD, depression, and anxiety symptoms. Therefore, predictive model results are highly contingent upon order of variable control and assignment of shared variance. Theoretical, research, and clinical implications of the findings will be discussed.

### Child Adjustment and Parental Trauma History: Data from the NFS

Daniel Smith, Medical University of South Carolina; Benjamin Saunders, Medical University of South Carolina; Linda Williams, Wellesley College; Rochelle Hanson, Medical University of South Carolina

Parental response following abuse discovery plays an important role in mediating a child's post-abuse adjustment. Although some attention has been paid to maternal responses, few data have addressed the impact paternal victimization history, or trauma exposure in both parents, on the adjustment of

children exposed to family violence. This paper will address these issues using data from the Navy Family Study (NFS), a prospective examination of families referred to authorities for intrafamilial sexual abuse, physical abuse or partner violence. Families were initially assessed within six weeks (T1) of the time of the report to authorities. Follow-up assessments were conducted 9 and 18 months post-report. Assessments consisted of interviews with the offending caregiver (OP), non-offending caregiver (NOP), and index child, and paper-and-pencil questionnaires. T1 data are currently available from 301 OP/NOP pairs, and data collection is ongoing. Data regarding parental exposure to interpersonal violence (adult and childhood sexual assault, childhood physical abuse, adult physical assault, and intimate partner violence) was used to group the 301 families into six categories representing differing levels of parental exposure. Analyses revealed high levels of exposure to trauma among OP's (eg, over 20% child physical abuse) and NOP's (eg, approximately 40% child sexual abuse). Child outcomes assessed via parent (CBCL) and child-report (Trauma Symptom Checklist for Children, Children's Depression Inventory) yielded many significant ( $p < .05$ ) differences according to parental level of exposure. Findings highlight complex relations among trauma exposure in family members and child adjustment.

### Complex Trauma in the Lives of Female Non-offending Parents

Victoria Banyard, University of New Hampshire; Linda Williams, Wellesley College; Benjamin Saunders, Medical University of South Carolina

This presentation will examine the role of childhood and adult traumas in the lives of women who are non-offending parents of children who have come to the attention of social services. Analyses were conducted using data on 384 women, a subset of a larger longitudinal study of families referred for services following a report of family violence. All of the women in the sample analyzed were non-offending parents who completed interviews and questionnaires about their own trauma histories, mental health, and exposure to various risk and protective factors including social support and family-of-origin relationships. Partner violence was associated with higher reported symptoms of anxiety, depression, intrusive experiences, avoidance, and dissociation on the Trauma Symptom Inventory. Childhood trauma variables were not found to be directly related to adult mental health, however a variety of childhood trauma was significantly associated with having experienced increased levels of partner violence. Further within group analyses were conducted for the 171 women who were victims of partner violence. Multiple regression indicated the importance of relationship variables such as adult attachment and social support as protective factors for more positive mental health. We will conclude with a discussion of research and clinical implications.

### Psychiatric Morbidity Following Military Deployment

**Symposium (clin res) Dover B/C, 3 (GB)**

Mark Creamer, Australian Centre for Posttrauma Mental Health and University of Melbourne; Brett Litz, Psychiatry Dept., Boston University School of Medicine and Psychology Dept., Boston University

This symposium includes a series of three papers outlining the nature of psychiatric problems experienced by military personnel following deployment to combat and peacekeeping theatres. The papers also examine the course of these psychiatric sequelae, with an emphasis on factors that impact on their maintenance and response to treatment.

### PTSD Rates and Psychiatric Co-Morbidity in Canadian Peacekeepers

Don Richardson, Veterans Affairs and National Defense Canada

Psychiatric sequelae following UN peacekeeping missions are becoming increasingly evident. To investigate this observation the database collected from a survey completed by Veterans Affairs Canada (VAC) regarding the health status of the younger Canadian Forces (CF) veterans was analyzed. With a return rate of approximately 72 %, 2760 veterans were surveyed. The questionnaire included standardized scales such as the PTSD Checklist military version (PCL-M), the Centre for Epidemiological Study-Depression Scale (CES-D) and the Alcohol Use Identification Test (AUDIT) as well as general health measures. Results indicated significant increased rates of PTSD, Depression and Alcohol Use Problems in veterans deployed as peacekeepers

compared with veterans who were not deployed. The analysis also demonstrated a significant difference in the rates of PTSD and Alcohol Use Problem between Veterans who participated in traditional Peacekeeping compared to Veterans who participated in more recent “Peacemaking” missions where local factions are still at war. Results also demonstrate significant co-morbidity of depression and Alcohol Use Problems with PTSD. The rates of general health indicators such self-perceived health, current pain and physical impairment were also significantly higher in veterans deployed on peacekeeping missions.

**Factors Influencing C-R PTSD Symptom Change Following Treatment**

*David Forbes, Australian Centre for Posttraumatic Mental Health; Mark Creamer, Australian Centre for Posttraumatic Mental Health; Nicholas Allen, University of Melbourne; Graeme Hawthorne, Australian Centre for Posttrauma Mental Health; Peter Elliot Swinburne University; Tony McHugh, Austin and Repatriation Medical Centre; Paul Debenham; Austin and Repatriation Medical Centre; Malcolm Hopwood, Austin and Repatriation Medical Centre*

Combat-related PTSD is a difficult condition to treat, with existing studies demonstrating considerable variability in outcome. Investigations of factors that influence outcome have the potential to inform alternate treatment approaches to maximize benefits gained from interventions for the disorder. This study investigated factors influencing symptom change following treatment for 158 Vietnam veterans with combat-related PTSD. The study consisted of two sections. The first section involved a cluster analysis to identify subgroups of veterans based on their MMPI-2 profiles. This was followed by a repeated measures general linear model analysis to examine differential patterns of symptom change across the subgroups over a twelve month period. Cluster analysis identified three robust subgroups on the basis of their MMPI-2 profile. These groups differed in levels of personality disturbance and general psychopathology (most notably in the areas of externalisation, alienation, and propensity for acting out) and demonstrated significant differences in the patterns of recovery following a group-based cognitive-behavioral treatment program. The second section involved a series of hierarchical regression analyses examining the influence of PTSD severity, other primary areas of comorbidity and broader psychopathology on symptom change to 12 months. This study identified a significant influence of factors such as social alienation and anger on symptom change over time. Implications of the findings of the study for the delivery of treatment for veterans of military deployments will be discussed.

**Factors Maintaining Chronic Post-trauma Symptomatology**

*Stephanie Hodson, Australian Department of Defence; Ronald Rapee, Macquarie University*

In 1994, a study was undertaken into the effects of deployment on personnel who served on an Australian Defence Force peacekeeping mission to Rwanda. It was decided in the study to targeted psychosocial factors, as research in this area could yield important findings to assist health professionals in the management of personnel after future deployments. This paper is a summary of the major findings of a six-year research programme involving 365 Australian Defence Force Rwanda Veterans. Results indicate that there is a stronger relationship between loneliness and post trauma symptomatology than other psychosocial variables. A key element in the development and maintenance of post-trauma adjustment appears to be the individual's internal perception of their connection to their support networks. Furthermore modeling of relationship between variables revealed two possible pathways to distress, with loneliness mediating the impact of social support as well as having a direct effect on the self-reported level of trauma exposure at six years. These findings will be discussed in relation to theoretical and clinical implications.

**ABCs of Medication with Traumatized Children**

**Workshop (child) Laurel C/D, 4 (HB)**

*Lisa Amaya-Jackson, Duke University Medical Center, Center for Child and Family Health-NC; Judith Cohen, Center for Traumatic Stress in Children and Adolescents, Allegheny General Hospita; Craig Donnelly, Dartmouth-Hitchcock Medical Center*

Children and adolescents presenting with Posttraumatic stress disorder (PTSD) are being recognized and treated with increased frequency by community practitioners, with community rates varying depending on type and prevalence of trauma exposure. Children with PTSD are at increased risk for having comorbid psychiatric diagnoses; those who are exposed to interpersonal traumas, particularly intrafamilial maltreatment, often have clinical presentations that are exceedingly complex. Because of its complexity and frequent occurrence with other disorders, assessment of PTSD necessitates a broad based evaluation utilizing multiple informants and structured instruments specific to the symptoms of PTSD in youth. Pharmacological agents for PTSD treatment have received little empirical investigation in childhood. Given the current evidence-base for treating pediatric PTSD, cognitive-behavioral therapy (CBT) is the treatment of first choice. However, medications may play an important role in treating posttraumatic stress symptoms in children. Pharmacological treatment is used to target disabling symptoms of the disorder, which limit psychotherapy or child functioning, by helping children to tolerate working through distressful material in therapy and ameliorating impaired functioning such as sleep disturbance, hyperarousal, and other trauma symptom clusters. Reduction in even one debilitating symptom of PTSD can improve a child's overall functioning across multiple domains. Furthermore, comorbidity is the rule rather than the exception in child trauma victims, and medication management of these comorbid conditions needs to take into consideration the PTSD target symptoms as well. Pharmacological treatment should be based on a stepwise approach utilizing broad spectrum medications. In this workshop, possible treatment algorithms are presented to guide rational medication strategies for youth with PTSD, subsyndromal PTSD, and in PTSD that is comorbid with other psychiatric conditions of childhood.

**Helping Clinicians Identify and Assist At-Risk Bereaved Patients**

**Workshop (assess) Grand Salon II, 3 (GB)**

*Holly Prigerson, Yale University School of Medicine; Sherry Schachter, Memorial Sloan Kettering Cancer Center; Selby Jacobs, Yale University School of Medicine*

Although bereavement poses substantial risks for mental and physical illness, inappropriate health service use, and even heightened risk of death, training in the health professions offers little guidance in effective grief management. The focus of this workshop is to offer recommendations to improve interactions with bereaved individuals in general, and with respect to bereavement from traumatic circumstances, in particular. Recommendations include a discussion of what to say and what not to say when counseling bereaved individuals, and practices to implement as well as to avoid. Signs and symptoms of uncomplicated and complicated grief will be discussed, and a diagnostic algorithm for Complicated Grief provided. Barriers to effective bereavement therapy will be described in the context of the terrorist attacks on the World Trade Center with particular emphasis on identifying disenfranchised grievers (e.g. fiancées, close friends; individuals who were newly bereaved at the time of the attack). Additional emphasis will be placed on assessing, identifying, and ameliorating complications of vicarious traumatization. Health care providers are expected to gain a better understanding of how to communicate with and assist bereaved survivors of traumatic losses.

Friday: 2:30 p.m.–3:45 p.m.

**Culturally Competent Care:  
Can We Train People to Provide It?**

**Workshop (train) Grand Salon I, 3 (GB)**

*Carol Etherington, Vanderbilt University School of Nursing; Kaz de Jong, Doctors without Borders (Médecins Sans Frontiers)*

Terms related to culture are routinely used in discussion throughout today's health and mental health care systems. Cultural diversity, cultural sensitivity, cultural awareness and cultural competence are some that we often hear, yet their actual meaning and effective application is elusive. This workshop addresses training techniques that better prepare providers to work with multi-ethnic populations in their own community or in global settings. In crisis situations involving individuals or in post-trauma environments with mass casualties, conducting culturally relevant assessments and interventions has become an integral part of the practitioner role and responsibility. The workshop will explore the continuum of cultural competence, the characteristics and domains of culture. Case studies will be offered to illustrate practical application and to assist participants in understanding how we move through the continuum from "unconsciously incompetent" to the more desirable end of the spectrum. A self-assessment survey will be distributed for participants to reflect on their own cultural heritage, and a set of scenarios describing culturally complex situations will be discussed in small group sessions.

**4:00 p.m.–5:15 p.m**

**Poster Presenters of Track 3, Children and Adolescents, and Track 7, Culture, Diversity, Social Issues and Public Policy will be available to discuss their posters.**

**Grand Salon V, 3 (GB)**

**Expert Clinical Consultation**

**Consultation (practice) Falkland, 4 (HB)**

Christine Courtois, PhD, is a psychologist in independent practice and Cofounder and Clinical and Training Director, The CENTER: Posttraumatic Disorders Program, The Psychiatric Institute, Washington, DC. Courtois is an expert in the treatment of adult survivors of abuse in both inpatient and outpatient settings; general treatment of PTSD and complex trauma; treatment of dissociative disorders; delayed memory issues; treatment sequencing, psychotherapy principles and guidelines; risk management and ethical concerns in psychotherapy supervision and treatment; transference, countertransference, vicarious trauma and self-care issues in the treatment of trauma; teaching about trauma and trauma treatment.

**Trauma-Related Research  
Priorities and Programs at NIMH**

**Forum (clin res) Grand Salon III, 3 (HB)**

*Farris Tuma, Division of Mental Disorders, Behavioral Research & AIDS, National Institute of Mental Health; Regina Dolan-Sewell, Division of Mental Disorders, Behavioral Research and AIDS, National Institute of Mental Health; Linda Street, Division of Services and Intervention Research, National Institute of Mental Health, Denise Juliano-Bult, Division of Services and Intervention Research, National Institute of Mental Health*

Early research on traumatic stress established that traumatic stress reactions could lead to serious psychiatric symptoms, tended to be chronic in many victims, and were among the most prevalent of mental health problems. Recent studies have focused more on the sources of diverse symptoms in traumatized populations and on how symptoms remit or persist over time. Research on posttraumatic stress has become a major focus for understanding how a broad range of traumatic experiences can affect several biological systems important in development and healthy functioning. Past research has been very helpful in identifying risk and protective factors and clues for developing new interventions. Despite these advances, predicting which traumatized individuals will go on to develop PTSD remains a challenge, as does finding effective treatments for all who suffer. Converging multi-disciplinary studies have led to the development and testing of new preventive and treatment interventions. Research directions for the future point to pathways of discovery and improved intervention. This forum will provide: an overview of NIMH programs relevant to trauma studies; examples of current research projects; and highlight new research areas in need of further investigation.

**Preparing Applications for  
SAMHSA/Center for Mental Health Services Programs**

**Forum (commun) Galena, 4 (HB)**

*Jennifer Wood, National Center for Child Traumatic Stress; Rebecca Gaba, Children's Institute International, Central L.A. Child Trauma Treatment Center; Christine Guthrie, Center for Mental Health Services, National Child Traumatic Stress Initiative*

The Substance Abuse and Mental Health Services Administration (SAMHSA) is a federal agency within the U.S. Department of Health and Human Services that seeks to reduce the costs to individuals and society caused by substance abuse and mental illness. As part of that mission, SAMHSA Centers fund community-based service delivery projects aimed at improving the quality and availability of prevention, treatment, and rehabilitation services for those with mental health or substance abuse disorders. Special populations of interest to SAMHSA's Center for Mental Health Services (CMHS) include homeless populations, persons in the criminal justice system, refugees, women, minorities, older adults, and rural populations. CMHS also has significant investments in services for children and adolescents, suicide prevention efforts, and

Friday: 4:00 p.m.–5:15 p.m.

programs addressing workplace, domestic, and school violence. In this forum, ISTSS members who have successfully applied for support from SAMHSA will describe their experiences with the application and funding process, focusing particularly on aspects of the applications and the applications process that are distinctive, compared to those of other funding sources. A representative from SAMHSA will also be available to answer questions about funding opportunities and the applications process.

### Intervention after Chemical, Biological and Radiological Attack

Panel Discussions (train)

Dover A, 3 (GB)

*Elspeth Ritchie, DoD/Health Affairs; Arieh Shalev, Department of Psychiatry, Hadassah University Hospital; Nozomu Asukai, Tokyo Institute of Psychiatry; Ross Pastel, United States Army Medical Research Institute of Infectious Diseases*

The importance of psychological reactions following chemical, biological and radiological events has now been recognized. Numerous examples abound, to include the radiation event at Goiania, the sarin attack in Japan, the impact of the Scud missiles on Israel and the recent anthrax attacks in the USA. Strategies on how to prevent or mitigate these reactions are now being developed. Education and training of mental health providers, first responders, media and the public is needed. Knowledge and accurate information should reduce anxiety, if communicated in a consistent and timely fashion. It is assumed that the principles of early intervention following disasters and other trauma will be useful after CBR. However, the potential for contamination and contagion argues for some different approaches for delivery. Classic "town hall" strategies of health risk communication, and group "critical event debriefings" may be contraindicated. The Internet may be critical. Other strategies implemented by planners and first responders may have critical mental health consequences. For example, prior training and exercises in the use of protective gear and evacuation may prevent panic. Timely information about biological and chemical agents should be delivered by responsible media and public affairs.

### Post-traumatic Stress After Injury or Residential Fire

Symposium (clin res)

Dover B/C, 3 (GB)

*Nancy Kassam-Adams, Children's Hospital of Philadelphia*

Presenters will describe several recent prospective investigations concerning post-traumatic distress in adults and children after physical injury or residential fire. The symposium will highlight factors associated with psychological distress and recovery, and provide an opportunity to compare the nature and course of adult and child responses to single incident traumas.

### Predictors of Posttraumatic Distress in Residential Fire Survivors

*Anne Keane, University of Pennsylvania School of Nursing; Arlene Houldin, University of Pennsylvania School of Nursing*

Little attention has been given to psychological recovery from residential fires. A review of the disaster, bereavement, attributions and residential fire literature identified a set of factors likely to influence survivors' post-traumatic stress responses to residential fires and their aftermath. These included degree of loss, personal characteristics of survivors, and cognitive and emotional responses of victims including perceived vulnerability, sense of control, blame of others, and asking "Why me?." In a series of studies, recovery following residential house fires was examined. The first study evaluated the self-identified unmet needs of adults and children recovering from residential fires. The second study examined the set of factors believed predictive of post-traumatic psychological distress after residential fires. 440 survivors were interviewed at 3, 6, and 13 months to measure post-traumatic stress symptoms. Distress was high at 3 months and decreased for the majority, although 1/3 had higher distress at 13 months than at 3 months. Loss of control and attributional variables had the strongest influence on post-traumatic psychological distress over time. These findings are consistent with expected stress-response tendencies after a stressful event and identify a set of predictors to help clinicians target survivors at high risk for post-traumatic distress after a fire.

### Residential Fire: The Effect of Parents' Distress Reactions on Children

*Russell Jones, Virginia Polytechnic Institute and State University; Thomas Ollendick, Virginia Polytechnic Institute and State University, Psychology, College of Arts; Jae Bodas, Virginia Polytechnic Institute and State University, Department of Clinical Psychology*

The present study is a follow-up to an earlier investigation that examined the relationship of parents' psychological distress with their child's level of distress following a residential fire. In the initial study, sixty-eight children and adolescents ages 6 to 18 and a parent served as participants. Participants completed the following measures during individual interviews: The Fire Questionnaire (Jones and Ribbe, 1990), Parenting Style Questionnaire (McFarlane, 1987), Fire Related Traumatic Events Scale—Children (Jones, 1996), Children's Reaction To Traumatic Events Scale (Jones, 1996), Diagnostic Interview for Children and Adolescents (DICA; Reich and Welner, 1990), DICA: Parent Version (Reich and Welner, 1990), and Brief Symptom Interview (BSI; Derogatis, 1983). Parents' reports of their own symptoms on the BSI and parent-reported child depressive symptoms on the DICA: Parent Version were significantly correlated. Similarly, significant correlations were obtained between parents' symptoms on the BSI and parent-reported child PTSD as measured by the DICA: Parent Version. These findings will be discussed in light of their implications for parent and child behavior following residential fires. In the present study we explore several of these relationships with 140 child-parent pairs, as well as the relationship between adult religious coping and child non-religious coping.

### Contribution of Psychological Distress to Postinjury Disability

*Therese Richmond, University of Pennsylvania School of Nursing*

Recovery from physical injury has focused on repair of anatomic injury, restoration of physiologic stability, and compensation for functional loss. While reducing mortality and morbidity, these approaches have been found lacking in maximizing recovery. A series of studies aimed at identifying injury-related, posttraumatic psychological stress symptoms, and social predictors of short- and long-term disability following serious injury were conducted. A cohort of 109 adults was followed for 3 months with a subset of 63 for an additional 2 years postinjury. Injury-specific information was obtained from the medical record and posttraumatic stress symptoms were assessed via patient interview. Injuries stemmed from violent (36%) and non-violent (74%) causes, resulting in a mean injury severity score of 15.5. In the short-term, injury type, intrusive thoughts, and individuals with less education had more severe disability. At 2 years, pre-injury (age and pre-injury disability), in-hospital (posttraumatic psychological distress) and 3 month post-discharge factors (posttraumatic psychological distress and short-term postinjury disability) were early predictors of long-term disability. These factors accounted for 36% of the variation in disability. The findings of these studies demonstrate that posttraumatic stress symptoms are the major contributor to postinjury disability and that patients with posttraumatic stress symptoms can be identified early postinjury.

### Pediatric Injury: Posttraumatic Stress, Recovery, and Family Impact

*Nancy Kassam-Adams, Children's Hospital of Philadelphia; Chiara Baxt, Children's Hospital of Philadelphia and Fordham University; Flora Winston, Children's Hospital of Philadelphia and University of Pennsylvania*

PTSD has been identified in children and their parents following pediatric injury. However, posttraumatic psychological distress appears to be unrelated to the severity of the acute physical injury. This presentation will address the relationships among child and parent posttraumatic stress, the child's physical and functional recovery, and the potentially broader family impact of injury. In a prospective study of post-traumatic stress following pediatric injury from traffic crashes, 250 children and adolescents (age 8 to 17) and their parents were assessed within one month post-injury and again 4 to 8 months post-injury. The follow-up assessment included evaluation of child PTSD symptoms (CAPS-CA interview), parent PTSD symptoms (PTSD Checklist), the child's physical recovery (Child Health Questionnaire), and effects on the family (Impact on Family Scale). There was a significant, moderate association between child and parent PTSD severity at follow-up. Both child

and parent posttraumatic stress had a moderate inverse association with the child's level of physical recovery and general health, and a moderate association with the degree of impact of this injury on the family. Implications for integrating psychological care for children and their families within the context of acute and ongoing medical care after a traumatic injury will be discussed.

**Evidence-Based Treatments for Co-occurring PTSD and Substance Abuse**

**Symposium (clin res)**

**Grand Salon II, 3 (GB)**

**Featured Session**

*Lisa Najavits, Harvard Medical School/McLean Hospital*

This symposium offers three investigators' clinical insights and research results in testing psychotherapies for the dual diagnosis of PTSD and substance abuse. The three investigators' work represent a range of characteristics considered "complex": urban, severe histories of PTSD and substance abuse, low socioeconomic status, methadone-maintained, in prison, with multiple life problems.

**Substance Dependence-PTSD Therapy: Outcomes of a Pilot Trial**

*Elisa Triffleman, The Public Health Institute; Philip Wong, The Public Health Institute; Celeste Monnette, The Public Health Institute*

PTSD among addicted persons is frequent, and significantly worsens the prognosis for functionality and successful treatment outcomes. There is a continuing need to identify workable treatment interventions for this population. Final outcome results from a trial comparing Substance Dependence—PTSD Therapy (SDPT), including the use of prolonged exposure, with Cognitive-Behavioral Coping Skills Therapy (CBCST) for substance dependence alone will be presented. Subjects were recruited from a methadone clinic. Inclusion criteria: ability to read English at a 5th grade level; current partial PTSD and full lifetime PTSD; and >1 day of substance use in the past month. Exclusion criteria: severe homelessness; residential treatment facility participation; schizophrenia, schizoaffective disorder, severe major depression or untreated mania. Results: 36 subjects were randomized; 34 attended > 1 session. 56% female; 47% African-American, 14% Latino; 80% unemployed. At baseline, 74% had current PTSD; median CAPS severity was 72 (range: 33-105); PDS severity was 31.1 + 9.3. Ss used substances 15+ 11 days/past month. SDPT subjects attended more treatment sessions (mean 26.1 + 10.1) than those in CBCST (18.8 + 10.7). SDPT and CBCST resulted in comparable decreases in magnitude of PTSD and drug abuse severity over time at all timepoints through 1.5-year posttreatment follow-up. Conclusion: Methadone-maintained subjects tolerate treatment with and without prolonged exposure with acceptable outcomes.

**Treatment Outcomes in Women with Comorbid Substance Use and PTSD**

*Denise Hien, St. Luke's-Roosevelt Hospital; Lisa Cohen, St. Luke's-Roosevelt Hospital; Gloria Miele, St. Luke's-Roosevelt Hospital; Lisa Litt, St. Luke's-Roosevelt Hospital*

Findings demonstrate that the majority of treatment-seeking women presenting to addictions programs have a history of complex trauma and multiple associated impairments. Yet, most clinical trials on SUD (substance use disorders) rely on samples largely composed of higher functioning, stable patients with little comorbidity. The current study aimed to address this dichotomy by: a) using a more representative sample, b) examining the efficacy of an integrated SUD and PTSD treatment model (Seeking Safety), and c) assessing a comprehensive range of treatment outcomes. Two active treatments were compared to each other and to a non-randomized comparison treatment-as-usual (TAU) condition in a sample of 100 urban women dually diagnosed with PTSD and SUD. Findings on primary outcomes showed that participants in both active treatments had significant decreases in substance use, PTSD and psychiatric symptoms as compared to those in the control group. To expand on these results secondary analyses will also be presented examining the impact of treatment on symptoms falling within the Disorders of Extreme Stress Not Otherwise Specified (DESNOS) diagnostic construct.

**Seeking Safety Therapy: Outcomes for Women in Prison**

*Lisa Najavits, Harvard Medical School and McLean Hospital; Caron Zlotnick, Brown University and Butler Hospital; Damaris Roshenow, Brown University and Butler Hospital*

This presentation will focus on outcome results of a pilot study testing the Seeking Safety therapy for PTSD and substance abuse for women in prison. Seventeen women participated in the trial, which used a group version of the treatment. The attendance rate for the treatment was 83% of sessions and measures of client satisfaction were high. Of the 17 women studied, nine (53%) no longer met criteria for PTSD at the end of the three-month treatment, as measured by the CAPS; at a follow-up three months later, 46% still no longer met criteria for PTSD. Substance use could not be assessed while the women were in the controlled environment of prison, but a follow up six weeks after release from prison indicated that 70% did not meet criteria for substance use disorder. Recidivism rate (return to prison) was 39% at three month followup, a rate typical of this population. Clinical insights in adapting treatment to this population will be discussed as well.

**Evaluation and Treatment of Childhood Violent and Medical Trauma**

**Symposium (child)**

**Laurel A/B, 4 (HB)**

*Robert Murphy, Yale Child Study Center*

Findings from four approaches to assessment and intervention with children exposed to violent and medical trauma are presented with a focus on assessment of childhood trauma, coordinated police-mental health responses, and treatment of children affected by violent and medical trauma. Findings highlight children's adaptation to different types of trauma.

**Breaking the Intergenerational Cycle of Trauma with Early Intervention**

*Julian Ford, University of Connecticut Health Center; Karen Steinberg, University of Connecticut Health Center; Jennifer Haley, University of Connecticut Health Center*

The years from birth to kindergarten are a time of rich opportunity and significant vulnerability (Shonkoff and Phillips, 2000). Intergenerational cycles of trauma (Widom, 1999) compromise biopsychosocial development in very early childhood, foreshadowing costly long-term susceptibility to medical, psychological, and sociolegal problems (Ford et al., 1999; Lyons-Ruth and Jacobovitz, 1999). Despite increasing recognition of these pressing needs (Ford and Sanders, 2001), programs designed to break the intergenerational cycle of trauma beginning at or before birth are very rare. We describe two model programs designed to deliver evidence-based behavioral health care to parents at high risk for violence or crime and to their newborn children from birth through early childhood. The "medical home direct service" model provides substance-affected parents with direct behavioral health and trauma recovery services, supports, and home visitation embedded within a pediatric primary care clinic and a nearby family life education center. The "care coordination/mental health consultation" model is delivered by a multidisciplinary care coordination team serving Early Head Start and pediatric primary care settings with home visitation and linkages to community services for parents and mental health consultation to child care and preschool staff. First year externally-funded evaluation results will be described.

**Mental Health and Police Responses to Children Exposed to Violence**

*Steven Marans, Yale Child Study Center; Steven Berkowitz, Yale Child Study Center; Robert Casey, Yale Child Study Center; Robert Murphy, Yale Child Study Center*

First responders (police, firefighters, emergency medical providers) influence the mental health of acutely traumatized children and adolescents. They are constantly available in instances of violence exposure and acute traumatization, yet typically lack the training and resources to effect change at the crucial time of their response. The Child Development-Community Policing program extends mental health care systems to encompass police and justice personnel as partners in the delivery of care to children affected by violence in their homes and communities. Mental health professionals are placed in the community, with police, to develop collaborative strategies for intervening

Friday: 4:00 p.m.–5:15 p.m.

early when violence occurs. Findings highlight the ways that the program has altered the delivery of police, mental health and related services to children and families who are exposed to violence. These community response programs have forged working alliances between first responders and mental health providers in 14 municipalities, representing an emerging network for addressing the complex interplay of emergency response personnel and their mental health colleagues. First response professionals have become more attentive to their potential to ameliorate the sequelae of violence exposure and trauma on children's development.

### Acute Preventative Treatment for PTSD in Children in Medical Settings

Glenn Saxe, Boston University School of Medicine/National Child Traumatic Stress Network

There is a growing literature on treatment of acutely traumatized individuals in order to diminish the risk of PTSD. The medical setting is emerging as an ideal place to develop and test such acute preventative interventions. This presentation begins with a review of research findings on acute preventative interventions in medical settings. This review includes the findings on the administration of cortisol to patients hospitalized with septic shock, and the administration of propranolol and benzodiazepines to trauma victims in an emergency room. The presenter then describes his own naturalistic study of children hospitalized with a burn injury. The dose of morphine these children received while they were hospitalized was found to attenuate PTSD symptoms over six months following discharge. The development of new studies of such agents as gabapentin and clonidine to acutely injured children are described. Ideas regarding how these agents may stabilize neurobiological systems critical for processing the traumatic event, such as the noradrenergic, HPA axis systems, and the amygdala are outlined. It is concluded that the assessment of acute preventative interventions is a potentially highly productive line of research and that medical settings are ideal to conduct this research.

### Caregiver-Focused Therapy for Domestic Violence-Exposed Young Children

Patricia Van Horn, University of California San Francisco; Alicia Lieberman, University of California San Francisco

When young children are exposed to acts of violence between their parents, they experience a profound assault on their sense of self, their sense of psychological safety and their sense of whether others can be counted on to be reliable, loving, and protective. Because safe caregiving relationships provide the matrix in which young children develop, we intervene to enhance the quality of the parent-child relationship after exposure to domestic violence. This paper will discuss the ways in which relationship-based interventions accomplish the goals of recovery from trauma: regaining trust in bodily sensations, restoring affect tolerance and regulation, and processing traumatic memories. We will describe interventions that enhance the relationships of both the offending and non-offending parent with the child, and demonstrate that renewing the sense of safety in the parent-child relationship can restore the child to a positive developmental trajectory. Finally, we will present preliminary findings demonstrating the effectiveness of this method of intervention with a group of violence-exposed preschoolers and their mothers.

### The Complex Adaptation to Trauma in Very Large Epidemiological Samples

Symposium (complex)

Grand Salon VI, 3 (GB)

Featured Session

Endorsed by the Complex Trauma Task Force

Bessel van der Kolk, Trauma Center, Boston University

This symposium will present the results of three large trauma-related epidemiological samples, a Massachusetts Medicaid sample, the CDC ACE population, and an Australian population sample, totalling well over 100,000

individuals, and present 1) clinical presentations, 2) long-term adjustment, including health care utilization, 3) occupational adjustment 4) personality changes and 5) economic burden.

### PTSD Prevalence Rates in Very Large Treatment Seeking Medicaid Samples

Robert Macy, Trauma Center-Arbour Health Systems and Center for Trauma Psychology

Period prevalence rates of DSM III-R PTSD were studied in the Massachusetts Medicaid Mental Health and Substance Abuse Program. Among 85,000 enrolled Medicaid recipients seeking treatment, 55,931 received one of the five study diagnoses that included PTSD, Panic Disorder, Multiple Personality Disorder, Major Depression, and Bipolar Disorder. Interactions between period prevalence rates by study diagnoses, gender, multiple age and public assistance AID categories, and acute service utilization rates were investigated. Major Depression (n=21,842) ranked highest with an overall period prevalence rate of 390.5 per 1,000 (CI: 386.5-394.6). PTSD (n=19,775) ranked second highest with an overall period prevalence rate of 353.6 per 1000 (CI: 346.6-357.5). PTSD exhibited its highest period prevalence rate, 609.5 per 1,000 (CI: 601.0-618.0), for the study population in the youngest age group (5 to 12 years). Age-specific PTSD period prevalence rates for both the youngest age group and the aggregate of the two youngest age groups (5 to 18 years) far exceeded rates in both the other study diagnoses, and in all of the published rates for comparable child treatment seeking populations. This study may provide a unique first look at age-specific PTSD period prevalence rates for non-disaster treatment seeking youth populations.

### Epidemiological Evidence of the Burden of Disease for PTSD

Alexander McFarlane, The University of Adelaide; M. Creamer, Australian Centre for Posttraumatic Mental Health

The Australian Mental Health and Wellbeing Survey was a replication of the National Comorbidity Survey which examined a stratified sample of 10,600 people individuals. The aim was to assess the 12 month prevalence of common psychiatric disorders and personality disorders. The CIDI was the instrument used to define ICD 10 and DSM IV disorders. The burden of disease was assessed using the SF 12 and days affected by disability. The prevalence of PTSD was 3.3% according to ICD criteria and 1.34% using DSM IV criteria. PTSD was a greater predictor suicidal thinking than major depressive disorder. The prevalence of ICD 10 personality disorder was examined in the PTSD group with a comorbidity rate of 49.2%. PTSD was associated with higher levels of disability than depression, anxiety disorders and substance abuse. These data indicate the substantial burden of disease associated with PTSD. Kessler has suggested that PTSD and Major Depressive Disorder have the highest burden disease of all psychiatric disorders, a conclusion supported by these data. The morbidity associated with trauma and the need for this to be addressed in intervention strategies has not been grasped by mainstream mental health service policy makers in Australia.

### The Wide Ranging Health Effects of Adverse Childhood Experiences

Robert Anda, Centers for Disease Control and Prevention; Vincent Felitti, Kaiser Permanente

This presentation will clearly demonstrate how Adverse Childhood Experiences (ACEs) such as childhood abuse and neglect, witnessing domestic violence, and growing up with parents or household members impaired by alcohol abuse, illicit drug abuse, mental illness, and criminal behavior have an enormous long-term impact on the Nation's health. The ACE Study is the largest study of its kind ever conducted and includes a cohort of 17,443 members of the Kaiser Health Plan in San Diego, CA. Study participants were surveyed to assess the influence of adverse childhood experiences on health related behaviors such as smoking, alcohol and drug abuse, sexual behavior, reproductive patterns, social problems, as well as disease patterns and costs of medical care. Using the number of adverse childhood experiences in cumulative stressor models, the ACE Study has repeatedly demonstrated a strong, graded relationship to numerous important health risks and dis-

eases. Data from this Study strongly support the contention that ACEs are the single most important determinant of health and social problems in our country.

**Biological and Cognitive Abnormalities in PTSD with Psychotic Symptoms**

**Symposium (biomed) Grand Salon IV, 3 (GB)**  
 Steve Lindley, National Center for PTSD; Palo Alto VA HCS; Mark Hamner, Charleston VAMC/Medical University of South Carolina

Exposure to complex trauma may be associated with auditory and/or visual hallucinations and delusions with important treatment implications. This symposium will examine biological (cortisol regulation, eye tracking), cognitive (executive functioning, working and verbal memory) and symptom expression style (effort, unusual symptom combinations) measurements in patients with PTSD and psychotic symptoms.

**PTSD with Psychotic Symptoms; Eye-Tracking and Neuroendocrinology**

Frederic Sautter, South Central MIRECC, New Orleans VA HCS/Tulane University; Arleen Cerbone, Department of Psychology, Tulane University; Gina Mire, MIRECC, New Orleans VAMC; Garth Bissette, Department of Psychiatry, University of Mississippi Medical; Benjamin Schoenbacher, Department of Psychiatry, Tulane University Medical; Cherie Koenig, Department of Psychiatry, Tulane University Medical Center; Janet Johnson, Department of Psychiatry, Tulane University Medical Center; Barry Schwartz, Department of Psychiatry, Tulane University Medical Center

Recent studies have demonstrated high comorbidity between PTSD and psychotic symptoms. Studies have not been conducted to identify the abnormalities that may contribute to psychosis in PTSD. We report a series of studies that identify eye-tracking, neuroendocrine, and catecholamine abnormalities that are associated with PTSD with Secondary Psychotic Symptoms (PTSD-SP). Eye-tracking abnormalities are considered to be genetic markers for schizophrenia. A study comparing eye-tracking in PTSD-SP, nonpsychotic PTSD, schizophrenia, and healthy controls, shows that subjects with PTSD-SP differ from the other three groups in percentage of time in smooth pursuit eye movement (SPEM) ( $p < .0001$ ), that schizophrenics differ from controls ( $p < .001$ ), and that nonpsychotic PTSD SPEM performance does not differ from controls. This indicates that PTSD-SP shows a unique SPEM deficit, and it suggests that PTSD-SP may be associated with biological abnormalities that differ from both nonpsychotic PTSD and schizophrenia. Neuroendocrine data show that PTSD-SP is associated with levels of CRF that are higher than those found in nonpsychotic PTSD ( $p < .02$ ) and controls ( $p < .02$ ). Differences in catecholamine functioning will also be discussed. These studies show that PTSD-SP is associated with different characteristics than schizophrenia, and that it may be a subtype of PTSD.

**Cognitive and Symptom Expression Abnormalities in PTSD with Psychotic Symptoms**

Steven Lindley, National Center for PTSD; Palo Alto VA HCS; Eve Carlson, National Center for PTSD, Palo Alto VA HCS; Kimberly Hill, National Center for PTSD, Palo Alto VA HCS; Gilbert Villela, Stanford University Department of Psychiatry

Preliminary evidence suggests that the presence of psychotic symptoms in chronic PTSD has important clinical treatment and disease outcome implications in veterans with complex trauma responses. The object of the present, on-going investigation is designed to study the phenomenology of psychotic symptoms in PTSD in detail. Because of the similarities to major depression with psychotic features, we are assessing if cognitive deficits associated with psychotic depression are present in patients with PTSD with psychotic features. Subjects are being recruited shortly after admission to a residential treatment for chronic PTSD from combat exposure. To date, we have assessed 15 out of 26 consecutive admissions. Eight of the 15 (53%) have endorsed the presence of recent, non-substance abuse related, psychotic symptoms (8/8 auditory and 5/8 visual hallucinations, 1/8 delusions, 6/8 non-combat related). The battery of tests being administered assesses general intellectual ability, working memory, executive function, verbal memory, atten-

tion, and effort. We are also assessing symptoms response style with assessments including the Miller Forensic Assessment of Symptoms Scale (MFAST). Preliminary analyses indicate a significant relationship between complaints of visual hallucinations and scores on the MFAST. Data on cognitive and symptom measures on the completed dataset will be presented.

**Resilience And Trauma**

**Symposium (clin res) Grand Salon VII, 3 (GB)**  
 Andreas Maercker, University of Zurich

Unfortunately, previous emphasis on PTSD tended to obscure human resilience to trauma. It is now clear that in the aftermath of even the most adverse events, considerable numbers of individuals will show remarkably high levels of health and well-being. Recently research has come to appreciate resilient individuals and to study their attitudes and behaviors for clues to successful coping.

**Israeli and Palestinian Children in the Shadow of Terror**

Tamar Lavi, Dept. of Psychology, Tel Aviv University; Zahava Solomon, School of Social Work, Tel Aviv University

The psychological effects of the Israeli-Palestinian conflict and particularly the current "Intifada" were assessed in 1,200 adolescents. The sample consists of 6 groups of both Israeli and Palestinian youth. These adolescents were born at the outbreak of the 1st Intifada and grew up in the shadow of terror and violence. This study assessed the psychological effects of the Intifada in the form of PTSD, psychiatric symptomatology and future orientation. The role of the following vulnerability/resilience variables: agency and communication was examined. The constructs of resilience and vulnerability will be reviewed in light of the effects of sporadic and accumulated stress.

**Long-Term General Life Adjustment Among Vietnam Veterans**

Lynda King, National Center for PTSD and Boston University School of Medicine; Daniel King, National Center for PTSD and Boston University School of Medicine; Dawne Vogt, National Center for PTSD and Boston University School of Medicine; Michael Suvak, National Center for PTSD and Boston University; Dana Rabois Holohan, National Center for PTSD and Boston University School of Medicine

In this portion of the symposium, we will review a series of studies aimed at understanding long-term general life adjustment (facets of life satisfaction, psychosocial adaptation, and achievement) in a national sample of persons exposed to combat in Vietnam. A first study comparing Vietnam theater veterans, era veterans, and civilians revealed that, as a whole, theater veterans endorsed ample levels of satisfaction and achievement even on outcomes where statistically significant differences were found. While past research has shown that exposure to the stressors of war are strongly associated with PTSD, multiple regression found these same stressors only minimally related to adjustment outcomes. Significant associations were found between the coping strategies veterans used in the war zone and their later life adjustment, with several quadratic interactions between coping and combat exposure. Problem-focused coping was most effective at moderate levels of exposure and least effective at high and low levels of exposure. The severity of the stressor likewise moderated the association between veteran's appraisals of their experience (perceived benefits, perceived costs) and their long-term general life adjustment. Again, at high and low levels of exposure appraisals of costs were least influential, whereas at moderate levels they were most influential (negatively).

**Criminal Victimization, Resilience and Salutogenic Variables**

Andreas Maercker, University of Zurich; Julia Muller, University of Zurich

Much of the research and theory on traumatic events has focused on post-traumatic stress reactions and pathology. In this talk, we adopt a salutogenic (i.e., health promoting) rather than pathogenic perspective. Previous discussions of salutogenic factors have tended to confuse resilience with the absence of pathology, thus obscuring the possible lessons that might be learned from exceptionally healthy individuals. To advance this issue, we have attempted to distinguish pathogenic and salutogenic variables among individ-

Friday: 4:00 p.m.-5:15 p.m.

uals exposed to potentially traumatic events by utilizing a three-group distinction of traumatized individuals with PTSD, traumatized individuals without PTSD and average health, and traumatized individuals showing usually high levels of health. In this talk, we report data from a recent study of victims of non-sexual, criminal assault (time since trauma =  $5.4 \pm 2.1$  months; 59% female; age: 18-65 years). Of the 150 crime victims in the study, 30% showed trauma reactions (Posttraumatic Stress Disorder), 45% had normal health (i.e., did not have trauma symptoms), and 24% had exceptional health. Based on previous research on salutogenic variables, features of cognitive processing of trauma (Posttraumatic Cognitions Inventory; Foa et al., 1999) as well as social-cognitive (e.g., perceived acknowledgment as victim; Maercker et al., 2002) and interpersonal variables (disclosure of trauma; Mueller et al., 2000) were examined. Results showed that most of the salutogenic predictors were social-cognitive and interpersonal variables whereas pathogenic predictors consisted of cognitive trauma processing features. The salutogenic role of social-cognitive and interpersonal processes for resilience is discussed.

**OVC Guidelines for the Treatment of Child Physical and Sexual Abuse**

**Workshop (child) Laurel C/D, 4 (HB)**

*Benjamin Saunders, Medical University of South Carolina; Lucy Berliner, Harborview Center for Sexual Assault and Traumatic Stress*

This presentation will describe the results of a recently completed project funded by the Office for Victims of Crime (OVC) of the U.S. Department of Justice entitled, Guidelines for the Psychosocial Treatment of Intrafamilial Child Physical and Sexual Abuse. The OVC Guidelines were developed in a two-year process that included a professional staff, a National Advisory Committee of 14 child victim treatment experts, 30 contributors, and several major revisions. It is designed to serve as a basic reference guide for clinicians working with child victims of abuse and their families. Components of the OVC Guidelines include: 1) the specific criteria developed and used for rating the theoretical, clinical, and empirical support of treatment protocols, 2) summaries of 24 treatment protocols commonly used with child victims of abuse and their families, and ratings of their levels of theoretical, clinical and empirical support, 3) a set of general guidelines for the clinical assessment of child abuse cases, and 4) a set of 22 general guidelines for treatment of child abuse cases. The presentation will cover each component of the OVC Guidelines and discuss their implications for clinical practice and practice risk management. The OVC Guidelines are expected to be issued by the U. S. Department of Justice sometime in 2002.

**Behavioral Couple's Therapy for PTSD**

**Workshop (practice) Grand Salon 1, 3 (GB)**

*Candice Monson, Dartmouth Medical School; Karen Guthrie, Dartmouth Medical School; Susie Stevens, White River Junction VA Medical Center; David Riggs, Medical College of Pennsylvania; Paula Schnurr, Dartmouth Medical School*

One well-established psychosocial effect of PTSD is intimate relationship dysfunction. Relationship discord, divorce, intimate aggression, and deleterious partner effects have been associated with PTSD. Moreover, research has shown that intimate relationships may mitigate or aggravate the development or course of an individual's PTSD. While a number of authors have discussed the role of intimate relationship variables, or the inclusion of partners of traumatized individuals in treatment, there have been few empirical studies that have investigated the efficacy of conjoint treatment for PTSD. The overall purpose of this workshop is to provide practical information for delivering a behavioral couple's treatment (BCT) for PTSD. The established efficacy of BCT for other individual problems/psychopathology will be briefly reviewed. The types of intimate relationship problems typically found in traumatized couples, and standardized methods for assessing these problems, will be presented. The theoretical rationale underlying BCT for PTSD and preliminary outcome data supporting its efficacy will be presented. An overview of the treatment will be provided, and videotapes from treatment cases will be shown to illustrate the interventions. The workshop will conclude with a discussion of special issues to consider when treating dually traumatized couples and victims of different types of trauma.

**Application of Dialectical Behavior Therapy to Trauma-Related Problem**

**Workshop (complex) Grand Salon VIII, 3 (GB)**

*Amy Wagner, University of Washington, Dept. of Psychiatry and Behavioral Sciences; Kathleen Melia, Clinical Psychologist, Private Practice, Concord Wellness Center, Wilma, Delaware; Lizabeth Roemer, University of Massachusetts at Boston*

Dialectical Behavior Therapy (DBT) is a comprehensive psychotherapy developed by Marsha Linehan. It was originally intended/ designed to treat chronically suicidal individuals with borderline personality disorder, but has since been applied to a wide range of diagnostic groups sharing an underlying disruption of the emotion regulation system. DBT is structured by stages. The first stage targets behavioral dyscontrol with the goal of increasing safety and connection to the therapist. Stage II targets emotional suffering. Given the high rate of traumatic experiencing reported by individuals with BPD, emotional disruptions in Stage II often relate to past traumas. DBT thus has applications to both stabilization and treatment of complex clients with histories of traumatic experiences. The current workshop will overview Stage I and Stage II DBT, highlighting the applications of this treatment to individuals with trauma-related problems including emotion dysregulation. Clinical examples and practice will focus on the use of behavioral analyses, DBT skills, and informal exposure in the treatment of shame and dissociation specifically.

**Counter Transference in Complex PTSD**

**Workshop (practice) Kent A/B/C, 4 (HB)**

*Constance Dalenberg, Alliant International University; Jim High, University of Southern California; Judith Armstrong, University of Southern California*

It is generally recognized that clinical work with clients presenting with complex PTSD can be among the most difficult faced by modern trauma therapists. These clients often present with complex histories and clinical material characterized by great neediness often communicated in disguised ways; difficulties managing boundaries; intense affects and affect regulation difficulties, especially rage; sexualization of the therapy; and extremely difficult trauma histories. These often elicit strong counter transference and counter resistance in the trauma therapist. This workshop will use clinical material from cases of complex PTSD to illustrate the presentation, identification, and management of these difficult counter transference events. Participants will be encouraged to present their own reactions to this material and their own case material.

Friday: 4:00 p.m.-5:15 p.m.

**Friday Media Presentations**  
**8:00 p.m.—9:15 p.m.**

**Reclaiming Hope...In a Changed World**

**Media** **Grand Salon VIII, 3 (GB)**

*Sarah Gamble, The Traumatic Stress Institute*

This documentary video was produced with a grant from the American Psychological Association. The work addresses psychological and spiritual issues raised for United States citizens by the attacks of September 11th, 2001. Designed for diverse audiences including front line workers, teachers, those in the helping professions, parents, and other caregivers, the video features interviews with trauma experts Laurie Anne Pearlman, Ph.D., Ervin Staub, Ph.D., Karen Saakvitne, Ph.D., and Frank Putnam, M.D. among others. Facilitated discussion will follow the viewing.

**International Training of Psychosocial Trainers Held in Africa**

**Media** **Grand Salon VII, 3 (GB)**

*Nancy Baron, Transcultural Psycho-Social Organization*

An international training workshop is held annually in Uganda to train trainers how to train psychosocial and mental health helpers within their home countries. The training participants work in collaboration with the Transcultural Psychosocial Organization (TPO). In 2001, participants included professionals and paraprofessionals from the countries of Algeria, Cambodia, Nepal, Sri Lanka, Uganda, Sudan, Burundi, Namibia and the Netherlands. Molenwiek Films prepared this documentary film that was viewed on Dutch television. It is an educational video and exemplifies the process of training trainers in this 3 weeks course. It begins with the theoretical course, that took place in Kampala, and included an 11 step plan for “how to” implement psychosocial programs in developing countries. The film shows a creative participatory teaching process used to train these future trainers the skills needed to train others. The final training week takes place in the refugee camps in the north of Uganda. The trainees get to practice what they learned and facilitate training workshops for paraprofessional counselors and rural community leaders.

**8:00 p.m.—10:30 p.m.**

**If I Could**

**Media** **Grand Salon IX/X, 3 (GB)**

*Lee Anderson, Line Producer; Patti Obrow White, Director/Producer/Writer; Dr. Andrea Karfgin, psychological consultant on the film and Director of Trauma Services for Maryland*

This award-winning documentary tells the engrossing story of a courageous young woman who confronts the ghosts of her troubled past in a fight to keep her 12 year-old son James from falling prey to the same demons that nearly destroyed her. In doing so, she must reveal many of her own painful secrets to him. Showing a rare 20 year time-arc on film, the documentary introduces us to a 14 year-old Tracy, who was the focus of a CBS Reports one-hour documentary when she was in an alternative program for troubled kids. Now 35, Tracy is a single mother of four children, struggling to shield her own family from these powerful generational truths. She calls upon the same man, Bob Burton, her mentor in recovery, and the one whom she credits for helping her as a teen, to help save her son. Archival clips from the 1979 CBS film are interwoven with the new footage painting an intergenerational portrait of an American family attempting to heal from the cycles of abuse, abandonment, drugs and rage after decades of trauma. Narrated by Sally Field.

**9:15 p.m.—10:00 p.m.**

**Languages of Emotional Injury**

**Media** **Grand Salon VIII, 3 (GB)**

*Roger Simpson, University of Washington*

A documentary team filmed all of 17 programs in an innovative week-long program held in Seattle in April 2002. Poets, journalists, photographers, and trauma specialists collectively addressed how the languages of poetry and journalism convey the experience of traumatization and the experience of coping with that traumatic history. The documentary captures compelling poems from poets Daisy Zamora from Nicaragua, Breyten Breytenbach from Africa, Semezdin Mehmedinovic from Bosnia, and Jimmy Santiago Baca from U.S. Such journalists as Ted Conover and Nina Bernstein speak to ways that medium can speak to the trauma experience. Therapists, psychiatrists, corrections officers, victim advocates and others join the conversation. The documentary supports the importance of community dialogues about traumatic events and how to respond to affected persons.