

Wednesday, October 29

9:00 a.m.–12:30 p.m. and 1:30 p.m.–5:00 p.m.

Full Day

1 Movement and Action in the Transformation of Trauma

PMI (frag)

Grand Ballroom, 4th Floor

van der Kolk, Bessel, MD, Trauma Center, Boston University; Macy, Robert, PhD, Trauma Center; Gross, Steven, Trauma Center; Johnson Macy, Dicky, Trauma Center; Brighton, Pam, Trauma Center; Grijalva, Frank, Trauma Center
TECHNICAL LEVEL: Intermediate

Trauma affects the total organism: neurobiologically, psychologically and socially. Traditional psychotherapy has approached the resolution of trauma as something that needs to be understood, worked through and put into the larger perspective of one's life. In the wake of the emerging research on the neurobiology of trauma, its effects on HRV, immune function and other issues related to self-regulation, physical helplessness, loss of executive functioning, and difficulty engaging in collaborative relationships, our Center, with numerous consultants, is engaged in a variety of programs exploring the use of collaborative movement and action, both in the aftermath of trauma, and in the treatment of chronically traumatized individuals. This includes theater groups with traumatized inner city youth in Boston, and a 12 session threat and terror stress inoculation program for elementary and middle school in the Metro Boston and Cambridge Primary School systems. The latter program is an extension of the Classroom Based Intervention (CBI) originally developed for use with 75,000 homeless youth after the Turkish earthquakes of 1999, and, in collaboration with Save the Children and USAID, in the Middle East with children and youth exposed to armed conflict. Outcome data that demonstrate increased self-efficacy, creativity, ability to appreciate other's point of view, and decreased re-enactments and intrusions, will be presented for several of these programs. This pre-conference workshop will explore how experience itself, and controlled bodily action, individually and in groups, can help overcome traumatic repetitions and continued fight/flight/freeze responses. The faculty will demonstrate, with the help of live demonstrations, videotapes, and handouts, how body-centered approaches and improvisational and ritualized theater groups can help people regain a sense of mastery and communality that is unlikely to be achieved by talking and meaning-making alone and present the research methodology and research findings that support the utility of such approaches.

2 How to Implement Prolonged Exposure for Chronic PTSD

PMI (practice)

State Ballroom, 4th Floor

Foa, Edna, PhD, University of Pennsylvania; Hembree, Elizabeth, PhD, University of Pennsylvania; Riggs, David, PhD, University of Pennsylvania
TECHNICAL LEVEL: Basic

Chronic posttraumatic stress disorder (PTSD) is an often complex and challenging disorder for clinicians to treat. But with a lifetime prevalence ranging from 6% to 12% of the population, and in the aftermath of recent terrorist events in the U.S., it is likely that clinicians will continue to see a sizable number of clients with PTSD and other trauma-related pathology. In this workshop, Edna B. Foa, PhD, Elizabeth A. Hembree, PhD, and David S. Riggs, PhD, will provide instruction in the use of Prolonged Exposure (PE), an empirically validated and highly efficacious cognitive behavioral treatment for chronic PTSD. Following a brief summary of the background theoretical and empirical work underlying PE, the presenters will describe the components of the treatment, and will illustrate these interventions with excerpts from videotaped therapy sessions.

3 Emerging Practices in Early Post-Trauma Intervention

PMI (disaster)

Crystal Room, 3rd Floor

Endorsed by the Early Interventions Special Interest Group

Ruzek, Josef, PhD, National Center for PTSD, VA Palo Alto Health Care System; Orner, Roderick, PhD, Department of Clinical Psychology, Lincolnshire (England) Healthcare Trust; Bryant, Richard, PhD, University of New South Wales; Kassam-Adams, Nancy, PhD, Children's Hospital of Philadelphia; Watson, Patricia, PhD, National Center for PTSD; Shalev, Arieh, MD, Hebrew University; Hadassah School of Medicine and Early Intervention; Resnick, Heidi, PhD, Medical University of South Carolina
TECHNICAL LEVEL: Intermediate

In this Pre-Meeting Institute, leaders in the development of early intervention methods to prevent trauma-related problems will provide practical guidance about secondary prevention based on clinical experience, ongoing treatment development, and research. First, Dr. Roderick Orner of the Department of Clinical Psychology, Lincolnshire (England) Healthcare Trust, will provide an overview of the current state of early intervention practice. Dr. Richard Bryant of the University of New South Wales will then provide training in cognitive-behavioral interventions being evaluated with motor vehicle accident and assault survivors with acute stress disorder. He will discuss delivery of several of the components of this evidence-based approach, including exposure treatment and cognitive restructuring, using case examples to describe the interventions in detail. Dr. Nancy Kassam-Adams of Children's Hospital of Philadelphia will explore recent thinking regarding the adaptation of adult preventive interventions for children. She will address the interplay between child and family responses to trauma, describe a recently developed practical screening tool for use with children and parents, and discuss ways of involving parents as resources for children's recovery from trauma. The next two presentations will describe adaptations of treatment to fit the delivery contexts of terrorism. Dr. Patricia Watson, from the National Center for PTSD, will discuss an adaptation of cognitive-behavioral treatment for survivors of the 9-11 World Trade Center attacks. Dr. Arieh Shalev, of Hebrew University and the Hadassah School of Medicine, will explore ways of moving the field from a "salient event/acute response" model (the core model of PTSD, given the disorder's status as "post" trauma) into a continuous adversity model, recognizing that many people are experiencing ongoing exposure to terror (e.g., domestic violence, crime, and terrorist attacks), not single events. Finally, Dr. Josef Ruzek from the National Center for PTSD will summarize and consider near-term changes in early intervention practice that are emerging in the field.

Wednesday, October 29

9:00 a.m.–12:30 p.m.

Morning

4 Risk Management in Trauma Treatment

PMI (practice)

Wabash Room, 3rd Floor

Courtois, Christine, PhD, Psychiatric Institute of Washington and Private Practice; Turkus, Joan, MD, Psychiatric Institute of Washington and Private Practice; Brown, Laura, PhD, Argosy University, Seattle and Private Practice
 TECHNICAL LEVEL: Intermediate

Individuals with trauma histories (especially complex trauma) often enter treatment with a number of personal/developmental and relational/attachment vulnerabilities in addition to their PTSD symptoms. Personal/developmental vulnerabilities include insecure and/or disorganized attachment to primary caregivers and resultant developmental deficits. These deficits can include an excessively negative self-concept, profound despair, ineffectiveness and powerlessness, and difficulty managing emotions leading to dysfunctional self-soothing methods such as self-injury, risk-taking, substance abuse, suicidality and, in some cases, threats to others. Relational/attachment vulnerabilities include insecurity; fear and mistrust of others; and unstable and chaotic relationships. These personal and relational vulnerabilities, alone or in interaction with the PTSD and dissociative symptomatology often result in conditions of risk for the client and, by association, for the therapist. Furthermore, they result in transference manifestations and relational dilemmas that, in turn, stimulate countertransference responses in the therapist. These risks and relational patterns have been helpfully labeled by one writer as “treatment traps and dilemmas” associated with treating individuals with trauma histories. Clinicians who treat this population have numerous responsibilities, starting with the need to be informed about the condition and its attendant vulnerabilities and risks. They have a major responsibility to “Do no more harm” through their therapeutic interactions and interventions. They must be scrupulous in the maintenance of professional standards and boundaries and must carefully exercise clinical judgment in the client’s best interest, optimally in consultation with professional colleagues. This institute will review major areas of vulnerability and risk in treating cases of complex trauma and will present general treatment principles and guidelines that attend to issues of liability and risk management. Case examples will be used to illustrate a variety of treatment traps and dilemmas in clinical practice. Examples of ethical and professional management of these types of concerns will be offered and contrasted with examples of therapists’ indiscretions and transgressions. The latter create conditions of liability, but most importantly, create conditions of retraumatization rather than healing for the already highly traumatized client.

5 Community-Based Responding After Violence in Indigenous Communities

PMI (culture)

Parlor F, 6th Floor

Stamm, B. Hudnall, PhD, Institute of Rural Health, Idaho State University; Higson-Smith, Craig, MA, South African Institute for Traumatic Stress
 TECHNICAL LEVEL: Intermediate

The interplay between helper and helped in communities affected by cultural trauma and violence requires understanding both the culture of the community and the culture of those who would come from the outside to assist with healing. This workshop discusses theory and research related to working with diverse ethnic groups in community. The workshop is divided into three sections: (a) the culture of the traumatized community; (b) the culture of the helpers; and (c) the interaction of the culture and the helpers. The workshop will open with an overview of the theory of cultural trauma as developed by B. Stamm and H. Stamm. The presentation will continue with a review of the idioms of distress in westernized and non-western cultures as conceptualized by B. Stamm and Matthew Friedman. Following these presentations, Higson-Smith will discuss negative and positive resilience as posed by Merle Friedman and Higson-Smith. The session continues with a discussion of workers in

terrifying situations who may experience potentially traumatizing events, either directly or indirectly. The authors posit that there are things that can be done by the individual, the work group, the agency, and even through culture that are protective for traumatic stress workers, whether they are community members or outsiders who offer assistance following a community upheaval. The presenters will explain some of the complexities of the experiences encountered by those who work in terrifying situations, where workers simultaneously may be exposed to a malevolent environment through indirect trauma (secondary or vicarious), and/or to direct trauma. The presenters will provide information on biological and psychological risks and protective factors, based on a person-event model, that can influence an individual’s work and competency and contribute to both positive and negative resiliency. The materials will be summarized by examining a model of culture (part of culture, not part of culture) by exposure (direct, indirect) and its use in communities affected by violence. The session concludes with recommendations for supporting both community members and outsiders working in the community.

6 Nightmare Therapy: Integration and Resolution of Traumatic Memories

PMI (practice)

Parlor B, 6th Floor

Daniels, Lori, PhD, Department of Liberal Arts, Hawaii Pacific University; Donovan, Beverly, PhD, Department of Veterans Affairs Medical Center; Padin-Rivera, Edgardo, PhD, Department of Veterans Affairs Medical Center; Scurfield, Raymond, DSW, University of Southern Mississippi, Gulf Coast; Forbes, David, PhD, University of Melbourne
 TECHNICAL LEVEL: Intermediate

Traumatic events can result in the fragmentation of a survivor’s psyche, resulting in recurrent, traumatically based nightmares and other forms of reexperiencing symptoms. Survivors often report suffering from dreams that reference traumatic incidents. The reoccurrence of traumatic dreams and intrusive memories have long-term, negative impact on other areas of a survivor’s life and can result in difficulties with occupational and interpersonal relationships. A clinician’s ability to use the content of dreams as a source of information and therapeutic reintegration of traumatic memories can expedite healing and resolution. This four-part institute describes five different techniques designed to reduce the frequency and intensity of trauma-based nightmares. The first part discusses the development of a nightmare assessment instrument with psychometric evaluation information. In addition, a method to create meaning within traumatic nightmares through a group treatment model is also presented with outcome data. The second part introduces a Gestalt method, using a one-session case example to illustrate the processing of traumatic events, and the outcome four years later. The third part discusses two methods of working with traumatic nightmares: sandplay processing and a writing technique. Each of these procedures will be illustrated using case examples and videotaped therapy sessions. The final part will describe treating traumatic dreams through imagery rehearsal. Findings from a recently completed 12-month pilot study using imagery rehearsal will also be presented. A major goal of each nightmare therapy technique is to minimize the influence of traumatic nightmares and resultant negative emotions on survivors. This institute is designed for intermediate or advanced clinical practitioners who wish to enhance their skills addressing specific traumatic memories that impact on their clients’ lives.

7 Cognitive-Behavioral Treatment for Type II Childhood Trauma Victims

PMI (practice)

Parlor H, 6th Floor

Boos, Anne, PhD, Technische Universitaet Dresden; Smucker, Mervin, PhD, Medical College of Wisconsin; Braun, Michelle, MS, University of Wisconsin Milwaukee
 TECHNICAL LEVEL: Intermediate

Victims of Type II childhood traumas typically manifest not only chronic PTSD symptoms, but struggle with numerous maladaptive core beliefs (schemas) relating to negatively distorted perceptions of threat, vulnerability, powerlessness, and self-efficacy. Because Type II trauma memories and associated beliefs are often encoded visually and senso-motorically and are not accessible by verbal

Wednesday, October 29
9:00 a.m.–12:30 p.m.
Morning (Continued)

techniques alone, imagery-based interventions have been increasingly applied in the treatment of PTSD where the distressing affect is directly linked to the victim's intrusive images and associated meanings. In this workshop, the presenters will offer an integrated CBT treatment model for Type II trauma victims that involve: (1) transforming the affectively-charged traumatic imagery into narrative language; (2) replacing victimization imagery with mastery/coping imagery; and (3) facilitating emotional self-regulation through the development of self-calming and self-soothing imagery. Through instructional video demonstrations, experiential exercises, case examples, lecture, and discussion, this workshop will demonstrate the use of imagery as a primary therapeutic agent to access, challenge, and modify trauma-related cognitions, intrusive images, and schemas. Participants will learn how the application of imaginal exposure, mastery/coping imagery, and self-nurturing imagery—combined with secondary cognitive processing and schema modification—can be applied to decrease physiological arousal, eliminate intrusive memories, replace victimization imagery with coping imagery, modify trauma-beliefs, create more adaptive schemas, and develop an enhanced capacity to self-nurture and self-calm.

8 The Multiple Realms of Fragmentation Experienced by Torture Survivors

PMI (practice)

Parlor A, 6th Floor

Okawa, Judy, PhD, Program for Survivors of Torture & Severe Trauma at CMHS; Gray, Amber, MPH, MA, Rocky Mountain Survivors Center; Fabri, Mary, PsyD, The Marjorie Kovler Center for Treatment of Survivors of Torture; Piwowarczyk, Linda, MD, MPH, Boston Center for Refugee Health and Human Rights, Boston University School of Medicine
TECHNICAL LEVEL: Intermediate

Survivors of politically motivated torture frequently describe feeling as if their personalities have been dismantled, fragmented, by their experiences of torture. The uncertain political climate in the U.S. since September 11 makes survivors vulnerable to exacerbation of fragmentation. This presentation will explore the multiple realms in which fragmentation occurs (fragmentation of the self, distortion of perceptions, fragmentation of the body, mind, and spirit, and fragmentation of social relatedness) and interventions will be proposed. The multiple ways in which torture victims experience fragmentation of the self will be explored through examination of the pattern of responses given by 60 survivors to the Trauma Symptom Inventory (TSI) in a review of archival data, revealing a broad range of dissociative symptoms. One of the long-term consequences of torture is a persistent vulnerability to perceptual distortions in times of stress. These distortions are directly related to the strategies of torture to dominate and instill fear and mistrust. Case material will be presented to illustrate examples of perceptual distortion and relational strategies. The meaning of these perceptual distortions within the context of torture and the utilization of the therapeutic relationship as a link to perceptions of reality will be discussed. The use of somatic psychology interventions, used both alone and in conjunction with other therapies, will be described as a means of addressing the disrupted sense of safety and somatic and relational fragmentation. Methods presented will be based on principles of somatic psychology and dance movement therapy and will draw from three case examples of work with survivors of long-term torture and war trauma. It is well known that trauma and torture significantly affect the social cohesion of individuals, families, and communities. Group interventions with a long-term psychotherapy group with Bosnian women and a multi-ethnic Women's Solidarity Dinner Group will be described and contrasted. The fulcrum of the healing process in the first group stemmed from the therapist's challenges to stretch beyond standardized treatment approaches. In the multinational women's group, the identification of common challenges faced by women from diverse backgrounds resulted in cultural identity serving as a grounding vehicle leading to group unity. Presentation will describe and make reference to clients' experiences of torture.

Wednesday, October 29,
1:30 p.m.–5:00 p.m.
Afternoon

9 Youth Trauma Assessment: Clinical Training by Instrument Developers

PMI (child)

Parlor F, 6th Floor

Rodriguez, Ned, PhD, Private Practice and Hathaway Children's Clinical Research Institute; Veitch Wolfe, Vicky, PhD, London Health Sciences Centre, University of Western Ontario; Sugar, Jeff, MD, Hathaway Children's Clinical Research Institute

TECHNICAL LEVEL: Intermediate

Instrument authors will conduct an interactive workshop designed to train clinicians in the use of an assessment battery of standardized measures developed to improve the clinical care of traumatized youth. They will present a comprehensive assessment model including child and parent report of youth's trauma history; peritraumatic reactions; and posttrauma symptoms, including PTSD and dissociation. Scale developers will provide hands-on training in the administration, scoring, interpretation, and integration of structured assessment into ongoing psychotherapy of traumatized children. The workshop will feature participant role-play practice. Participants will learn how to apply structured assessment information to specific clinical cases. Training will be provided on the following instruments: the History of Victimization Form, the History of Maltreatment/Traumatic Events Form, the Youth Trauma Screen, the Child Peritraumatic Reactions Questionnaire, the Children's Impact of Traumatic Events Scale-II, the Youth Peritraumatic Reactions Scale, the PTSD Index, and the Child Dissociative Checklist (Child and Parent Reports). Additional measures of youth depression, attributional style, coping, and anger will be discussed in their relationship to clinical cases. The workshop aims to provide clinicians with the introduction to the use of standardized assessment instruments necessary to incorporate and integrate structured assessment into their ongoing psychotherapy with traumatized youth.

10 Psychodynamic Group Treatment for PTSD

PMI (practice)

Parlor A, 6th Floor

Weiss, Daniel, PhD, University of California; Tichenor, Victoria, PhD, San Francisco VA Medical Center; Goodman, Marianne, MD, Mt. Sinai School of Medicine
TECHNICAL LEVEL: Intermediate

The main focus of this session will be on conducting group treatment of individuals with chronic PTSD, from any traumatic event, using the perspective of psychodynamic case formulation to identify the key issues that require attention in each member of the group. A second focus will be on the techniques of balancing individual versus group focus, and how the use of common themes that emerge can facilitate this process. Participants will also learn how to weave education elements about PTSD symptoms and course into a treatment approach that stresses group cohesion and individual autonomy rather than a prescribed agenda. Attention to transference issues, both individual and group, will be given, as will examples of various technical interventions to deal with problematic situations that arise uniquely in group treatment such as drop-out of members, conflict between members, and stances of members versus leaders. The primacy of the meaning of aspects of the trauma to both the individual and the remaining members will be a central focus. Finally, suggestions about pre-screening and minimal requirements for admission to this approach to group treatment will be presented.

Wednesday, October 29

1:30 p.m.–5:00 p.m.

Afternoon (Continued)

11 Terrorism and Disaster: Assessment and Triage of Children and Adolescents

PMI (disaster)

Wabash Room, 3rd Floor

Pfefferbaum, Betty, MD, JD, National Center for Child Traumatic Stress, University of Oklahoma Health Science; Pynoos, Robert, MD, MPH, National Center for Child Traumatic Stress, UCLA; Silverman, Wendy, PhD, National Center for Child Traumatic, Florida International University; Schreiber, Merritt, PhD, National Center for Child Traumatic Stress, UCLA; Gurwitsch, Robin, PhD, National Center for Child Traumatic Stress, Univ. of Oklahoma Health Science; Saltzman, William, PhD, National Center for Child Traumatic Stress, UCLA; Steinberg, Alan, PhD, National Center for Child Traumatic Stress, UCLA

TECHNICAL LEVEL: Advanced

Public mental health approaches in preparedness and response to weapons of mass destruction require a shift in clinician skills in conducting longitudinal pre- and post-event assessments of children, adolescents and families. There is an urgent need to develop, test and refine a set of assessment instruments and tools to evaluate the impact of terrorism on children and their families, their schools and communities. This PMI will discuss a comprehensive approach to systematically staging post-event surveillance, screening, triage, tracking, clinical assessment and monitoring course of recovery in the aftermath of terrorism and disaster. Stages of assessment include preparedness, response, mitigation and recovery. Dr. Robert Pynoos will discuss the overall conceptual framework for a public mental health assessment strategy, and the expansion of metrics needed at each stage. Dr. Wendy Silverman will discuss the development of a useful brief screen that can be employed to identify children with anxiety and anxiety sensitivity that are at risk for severe reactions to signs of danger (e.g., warnings, media messages, school safety drills, etc.) and to catastrophic events. Dr. Merritt Schreiber will describe an impact-phase web-based data entry, tracking and triage system called PsySTART, the current status of its development, and a model for linking data with child and family systems of care. Dr. Robin Gurwitsch will present data from preschool and school-age children following the Oklahoma City bombing and information gathered after the 9/11 terrorist attacks to discuss the nature, severity and course of psychological and behavioral reactions and best practices for assessment and triage. Dr. William Saltzman will present implementation strategies and metrics for a school-based protocol to screen students in their classrooms after catastrophic events, and to triage for appropriate mental health services at school or in the community. Dr. Alan Steinberg will conclude this PMI with a discussion of paradigms for multi-domain intervention outcome assessment and program evaluation indicators.

12 Working with Complex PTSD: Practical Individual Therapy Skills

PMI (practice)

Parlor H, 6th Floor

Munroe, James, EdD, Boston VA Outpatient Clinic; Fisher, Lisa, PhD, National Center for PTSD; Quinn, Stephen, PhD, National Center for PTSD; Abblett, Mitchell, PhD, Boston VA Outpatient Clinic; Pratt, Anne, PhD, The Traumatic Stress Institute, The Center for Adult and Adolescent Psychotherapy

TECHNICAL LEVEL: Intermediate

This Pre-Meeting institute is designed to provide an active learning forum for clinicians at the intermediate and advanced levels of conducting individual therapy with complex PTSD. This presentation complements the half-day institute on group therapy with complex PTSD. Much of our research and literature is based on specific traumas and short-term interventions delivered soon after the event. Many clients, however, have suffered a series of traumatic events over a prolonged period of time and they may present for therapy many years after the events. These clients may have been so extensively traumatized that they do not have the basic level of trust necessary to engage in some therapies. Such clients require thera-

pists with a wide range of skills and the ability to engage clients on their own ground. This institute will focus on identifying the therapeutic issues of complex PTSD as well as the practical skills and techniques that clinicians employ to help these clients. It will be facilitated by a number of highly skilled therapists whose diverse experience includes traumas such as combat, rape, domestic violence, and childhood physical and sexual abuse. The format will include structured exercises to promote active discussion of the issues. Issues will include: testing of trust, setting and maintaining boundaries, issues of power, when to do exposure, parallel process, dealing with aggression and threats, splitting, countertransference, re-enactment, ethical considerations, use of self, the effects of this work on therapists, and therapist self care. Participants should be prepared for an active experience and should be willing to engage in an exchange of ideas and experiences. A portion of the time will be provided for participants to present clinical material for discussion by the entire group. The institute will not focus on any particular theoretical approach, but will identify issues that are common to the processes of trauma therapy. Attention will be paid to maintaining the confidentiality of any case material presented and the institute will conclude with a debriefing to emphasize the importance of secondary exposure and therapist self care. Presentation will include material concerning psychotherapy issues that may be stressful for some audience members. Presenters will offer guidance about how to avoid this distressing material, and presenters will monitor the reactions of audience members throughout. There will also be a debriefing at the end of the PMI to address any distress-related issues and to promote self-care strategies.

13 The Joint VA/DoD Clinical Practice Guideline for Traumatic Stress

PMI (practice)

Parlor B, 6th Floor

Kudler, Harold, MD, Durham VA Medical Center; Friedman, Matthew, MD, PhD, National Center for PTSD, VA Medical Center, Dartmouth; Butterfield, Marian, MD, MPH, Durham VA Medical Center and Duke University Medical Center; Crow, Bruce, PsyD, Madigan Army Medical Center; McFall, Miles, PhD, Puget Sound VA Health Care System

TECHNICAL LEVEL: Intermediate

This workshop will review the process by which United States Department of Veterans Affairs (VA) and Department of Defense (DoD) have developed an evidence-based clinical practice guideline (CPG) for PTSD. Representatives from Army, Navy, and Air Force, VA Medical Centers, Readjustment Counseling Service (a community-based VA program originally created to help veterans of the Vietnam War but now serving combat veterans of all eras), and VA's National Center for Posttraumatic Stress Disorder (PTSD) have all collaborated on this task. The working group included psychiatrists, primary care physicians, psychologists, nurses, pharmacists, occupational therapists, social workers, counselors, and chaplains. A private contractor who has assisted in the production of past joint DoD/VA CPGs coordinated the working group's efforts. The goal of this project was to create an algorithm to aid field personnel and health care workers in identifying, assessing, and/or treating military men and women and veterans who have survived traumatic events. Such trauma may be related to combat, peacekeeping and humanitarian efforts, disaster response, sexual abuse or domestic abuse among others. This project is unique in that it offers a decision tree for prevention, assessment, and treatment with full annotation across a broad range of posttraumatic disorders. The clinical practice guideline informs and supports interventions of those working in the field without constraining them. Whenever possible, guideline recommendations have been fully referenced within the scientific literature but there are many areas in which expert consensus is the only basis for action. End users and consumers reviewed the CPG before it was finalized. The team is developing a set of outcome measures to ensure that the guidelines will have useful impact on practice and on overall health. Efforts will be made to integrate the guidelines into a computerized medical records system so that a clinical note is automatically generated as the clinician follows the algorithm. The CPG will be continuously monitored and refined in order to keep it current, credible, and practical.

Thursday, October 30
8:30 a.m.–12:00 p.m.
Morning

14 A Model System for Behavioral Health Bioterrorism Preparedness

PMI (disaster)

Wabash Room, 3rd Floor

Ford, Julian, PhD, University of Connecticut Health Center, Department of Psychiatry; Evans, Arthur, PhD, Connecticut Department of Mental Health and Addiction Services; Dailey, Wayne, PhD, Connecticut Department of Mental Health and Addiction Services; Berkowitz, Steven, MD, Yale University Child Study Center; Marans, Steven, PhD, Yale University Child Study Center; Dean, Kathryn, MSW, University of Connecticut Health Center Department of Psychiatry
TECHNICAL LEVEL: Intermediate

The Center for Trauma Response, Recovery, and Preparedness (CTRP) was established in October 2001 by the Connecticut Department of Mental Health and Addiction Services and Department of Children and Families in partnership with the University of Connecticut School of Medicine and Yale University School of Medicine. The Mission is to provide clinical, educational, and scientific expertise to behavioral health providers (professionals, natural helpers, prevention specialists, provider agencies), the broader healthcare and emergency response systems, policymakers and government agencies, and the general public in order to promote the safety and recovery of people affected by past or future bioterrorism. CTRP created a behavioral health bioterrorism preparedness system (BHBPS) by training and providing ongoing consultation and administrative coordination to regional and local teams, including more than 1000 behavioral health providers, 350 prevention specialists, and 350 advocates. Training and ongoing coordination address guidelines for safe and effective responding to acute post-traumatic stress and grief, and collaborative partnering with disaster recovery, emergency responder (fire, law enforcement, public health, emergency medicine, military), social and health services (hospitals, clinics, agencies, schools, shelters, child care, nursing facilities) providers and organizations to address the acute and long-term stress-related needs of children, parents, families, and older adults. This educational presentation is designed for traumatic stress clinicians, prevention specialists, healthcare and public safety administrators, emergency responders, and policymakers who want to have a template for developing a sustainable infrastructure for a behavioral health system that will be integrated in--yet distinct from--the incident command systems/structures for bioterrorism response. The presentation will include an overview of the developmental steps and organizational structure (funding, mission statement, organizational structure, networking with federal, state, local, and private organizations, community development and advocacy in diverse socioeconomic and ethnocultural communities, operational manual, sample educational presentations and materials, website development for system management and distance learning). The presentation also will provide live demonstrations of skill training and team development for responders, team leaders, and system administrators, including involving attendees in a bioterrorism simulation scenario used by the CTRP to enable regional BHBPS teams to test and enhance their readiness. Participants will engage in a simulation of a behavioral health command center following a hypothetical bioterrorism incident, including viewing a videotape with footage of an actual airline disaster and aftermath.

15 Working with Complex PTSD: Group Models and Interventions

PMI (practice)

Parlor H, 6th Floor

Niles, Barbara, PhD, National Center for PTSD, VA Boston Healthcare System; Wattenberg, Melissa, PhD, VA Boston Healthcare System; Glynn, Shirley, PhD, University of California at Los Angeles; Unger, William, PhD, VA Providence Healthcare System; McKeever, Victoria, PhD, National Center for PTSD, VA Boston Healthcare System
TECHNICAL LEVEL: Intermediate

Group therapy interventions, long considered optimal for trauma survivors, have only recently become a major focus of clinical research. This Institute complements the half-day institute on conducting individual therapy with complex PTSD and offers intermediate to advanced training in models of group treatment with proven effectiveness. The essential elements of both Trauma Focus and Present-Centered treatment will be presented in the context of data from a 10-site randomized VA trial supporting the efficacy of these treatments for combat veterans with chronic PTSD. These models have also been adapted for treatment of survivors of terrorist disasters, and for treatment of adults with childhood trauma. The Trauma Focus group is based on a skills-building and trauma exposure model and incorporates psychoeducation, coping skills training, exposure therapy, cognitive restructuring, and relapse prevention in a developmental perspective. The Present-Centered group is a supportive, process approach informed by schema theory for PTSD. Symptoms that disrupt orientation to current life are targeted, and group interaction is used as the basis for reframing trauma-based assumptions, affects, and behaviors, with psychoeducation as needed. In addition, three 12-week manual-based skills-building group therapies will be presented: Understanding PTSD (a psychoeducational group), Stress Management (utilizing relaxation skills and promoting healthy lifestyles), and Anger Management (discouraging aggressive and passive coping and supporting assertive behaviors). In this Institute, emphasis will be placed on implementing and maintaining active treatment in the face of challenges regularly encountered with trauma survivors, such as avoidance and numbing, trauma-based attitudes and beliefs, and high levels of affect and arousal. In addition, methods for dealing with common comorbidities (such as substance abuse, mood disorders, and personality disorders) will be offered. The Institute will cover: recommended staging of interventions; eliciting consistent attendance and participation; responding to trust and compliance issues; encouraging mid-range affects; 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.

16 Establishing and Protecting the Relationship with Traumatized Clients

PMI (practice)

Red Lacquer, 4th Floor

Dalenberg, Constance, PhD, Alliant International University; Gold, Steven, PhD, Nova Southeastern University; Courtois, Christine, PhD, The Center: Posttraumatic Disorders Program
TECHNICAL LEVEL: Intermediate

The mutual regard of client and therapist is one of the best empirical predictors of the success of longer-term treatment. The presenters believe that one source of the uneven success for complex trauma survivors in treatment is the disruption of the alliance that often follows from traumatic transference patterns and therapist countertransference. Clients with complex trauma histories often come to therapy with intense unmet dependency needs, distrust of authority, difficulty in attaching and maintaining collaborative relationships, and an inability to self-soothe or manage their dysregulated emotions. Therapists may become overwhelmed with their countertransference in such cases, withdrawing in fear from the dysregulated emotion, becoming frustrated at re-occurring misinterpretations of minor therapist behaviors, becoming angry at boundary pressure, and feeling confused as their empathy and professionalism at times seem to dictate different actions. The presenters will first re-acquaint the professionals with the common themes in such therapies from phenomenological, theoretical and clinical perspectives. Actual transcripts and clips from traumatized survivors will provide

Thursday, October 30
8:30 a.m.–12:00 p.m.
Morning (Continued)

the stimuli for these discussions. In the second (more major) part of the workshop, the presenters will present a series of actual therapeutic crisis points that put the relationship at risk. At various points in each scene, the action will stop and the audience will be given a chance to comment, or to add twists that they were forced to face in their own practices. The presenters will then give practical examples of clinical interventions, including the theoretical underpinnings for their own choices. Included among the issues will be a) the client who presses for therapist touch, b) the client who abuses telephone contact, c) the client who seems to have no attachment to others, d) the client who rages at the therapist for minor transgressions, and e) the client who sexualizes therapy. Special issues related to termination will be discussed in detail. The neurobiology of interpersonal relationships will also inform the discussion. The participants will be given opportunities to choose among scenarios based on their own interests and to offer their own discussion examples for the panel.

17 Treating Childhood Traumatic Grief: A Developmental Perspective

PMI (disaster)

Adams Ballroom, 6th Floor

Ley, Susan, LCSW, Wendt Center for Loss and Healing; Pynoos, Robert, MD, MPH, National Center for Child Traumatic Stress, UCLA; Cohen, Judy, MD, Allegheny General Hospital Center for Child Abuse and Traumatic Loss; Leiberman, Alicia, PhD, University of California, San Francisco; Layne, Christopher, PhD, Brigham Young University
TECHNICAL LEVEL: Advanced

Childhood traumatic grief (CTG) is a condition in which trauma symptoms impinge on children's ability to negotiate the normal bereavement process. This PMI will present the concept of CTG and developmentally informed empirically derived treatments for this condition in children from infancy through adolescence. Dr. Pynoos will discuss the concept of CTG and general principles of treatment for these children. Dr. Leiberman will present a parent-child relationship-based model for addressing the trauma of losing a parent or other central attachment figure early in life. This manualized treatment model was derived from Dr. Leiberman's evidence-based treatments for traumatized infants and preschoolers, and focuses on the importance of reestablishing and enhancing safety and attachment in the face of profound loss. Dr. Cohen will present an individual treatment model for school-aged and early adolescent children, which was derived from the evidence based Trauma-Focused CBT model. This treatment includes parallel and joint treatment sessions for children and their parents/primary caretakers, and includes sequential trauma- and grief-focused interventions. This model is currently being tested in an open study for children experiencing CTG from diverse causes, and in a randomized controlled trial among children who lost their firefighter parents in the 9-11 terrorist attacks in New York. Dr. Layne will present a school based, group treatment model of adolescents, which has been tested in Bosnian youth experiencing war related CTG. The majority of the presentation will focus on specific features of complicated bereavement that have emerged in youth's descriptions of their traumatic losses, and pairing this with specific treatment objectives within the context of trauma/grief-focused group psychotherapy. These include (a) reducing distressing intrusive images and emotional reactions relating to the circumstances of the death, (b) reducing avoidance and/or escape from loss-related cues, (c) increasing group members' capacities to realistically reconnect with their loved ones, and (d) helping group members to develop or restore a sense of purpose and meaning to their lives after the death of their loved ones. Case examples will be used throughout these presentations to illustrate treatment techniques and application of these models to children from diverse backgrounds.

18 Human Rights in Clinical Practice: Evaluations of Asylum Seekers

PMI (practice)

Parlor B, 6th Floor

Fabri, Mary, PsyD, The Marjorie Kovler Center for the Treatment of Survivors of Torture; McCarthy, Mary Meg, JD, Midwest Immigrant and Human Rights Center; Goldberg, David, MD, John Stroger Hospital of Cook County
TECHNICAL LEVEL: Intermediate

United States immigration law underwent tremendous changes after the 9/11 terrorist attacks. Persons who arrive in the United States fleeing persecution, especially asylum seekers, are at great risk of detention and deportation due to new enforcement policies. This population often includes survivors of torture and war trauma, who by virtue of their experiences, are least able to articulate the events that forced them into exile when faced with immigration proceedings, and are likely to be deported. For these individuals, forensic evaluations of their physical and psychological injuries can be critical for achieving asylum. Over the last decade, the torture treatment movement in the United States has grown, providing mental health professionals and physicians with new opportunities to participate in the treatment and protection of torture survivors. In this session, torture treatment professionals from three Chicago agencies that serve refugee communities, will provide an overview of the health consequences of torture and trauma in recently arrived asylees and discuss the role of health professionals in immigration proceedings. This presentation will consist of three sections. A lawyer from the Midwest Immigrant and Human Rights Center will begin by explaining current United States immigration law pertaining to persons fleeing persecution, the role of experts in asylum proceedings, and standards of evidence in immigration court. A psychologist from the Marjorie Kovler Center for the Treatment of Survivors of Torture will describe how to assess the degree of consistency between the account of torture and psychological symptoms, prepare an affidavit, and provide expert witness testimony. A physician from John Stroger Hospital of Cook County will describe common symptoms and physical findings of torture, and how to approach an examination and document the findings. Case studies will be used to illustrate psychological and medical forensic evaluations. Although the session will concentrate on the evaluation of non-detained torture survivors, participants will also learn about the challenges of working with individuals in Department of Homeland Security detention. The evaluation of unaccompanied abused immigrant children, persons subjected to human trafficking, and gender-based persecution will also be discussed. Finally, opportunities for participation in this meaningful work will be presented. Case summaries are based upon reports obtained from torture survivors, including details of their torture experience. Medical photographs of scars will be presented.

19 Management of Panic in Patients with PTSD

PMI (practice)

Parlor F, 6th Floor

Prins, Annabel, PhD, National Center for PTSD, San Jose State University; Falsetti, Sherry, PhD, University of Illinois, College of Medicine at Rockford; Swales, Pamela, PhD, National Center for PTSD, VA Palo-Alto Health Care System
TECHNICAL LEVEL: Basic

The purpose of this half-day Pre-Meeting Institute is to familiarize participants with the application and delivery of panic control treatment (PCT) in three traumatized populations: (1) community sexual assault survivors; (2) male combat veterans, and; (3) female veterans with history of military sexual assault. PCT is an empirically supported treatment for panic disorder (PD) developed in the 1980's by David Barlow and his associates. The high comorbidity between PD and PTSD (22-55%) has led to the development of innovative treatments that incorporate PCT in the treatment of PTSD. In this pre-meeting institute, participants will be provided with background information on PCT and then guided through the delivery of each PCT component: psychoeducation, cognitive restructuring, interoceptive exposure, and in-vivo exposure. Participants will be provided with materials to facilitate assessment, in-session exercises, and homework assignments. Issues and applications unique to each trauma group will be presented.

Thursday, October 30
8:30 a.m.–12:00 p.m.
Morning (Continued)

20 Rebuilding Multiply Fragmented Lives: Treating Trauma and Severe Mental Illness

PMI (clin res)

PDR #5, 3rd Floor

Rosenberg, Stanley, PhD, Dartmouth Medical School; Frueh, B. Christopher, PhD, Medical University of South Carolina; Harris, Maxine, PhD, Community Connections, DC; Mueser, Kim, PhD, Dartmouth Medical School

TECHNICAL LEVEL: Intermediate

Clients with severe mental illness (SMI) such as schizophrenia and bipolar disorder have high rates of exposure to trauma, and are at sharply increased risk for the development of posttraumatic stress disorder (PTSD). Despite the recognized need for effective interventions, standardized treatment programs have not been empirically validated. In this institute, we will describe three psychosocial interventions designed or modified specifically for treating clients with both SMI and PTSD. The first and newest intervention, developed by Frueh, Cusack, Buckley and Kimble incorporates elements of: a) patient education, b) exposure therapy with cognitive restructuring, c) anxiety management skills training, and d) social skills training. The treatment manual is being finalized in preparation for conducting an open trial in summer of 2003, and a small RCT is expected in early 2004. The second intervention, the Trauma Recovery and Empowerment Model (TREM), developed by Harris, Falloff and collaborators, is a 29-session group-based intervention that addresses PTSD and closely related consequences of sexual and physical abuse. TREM uses cognitive restructuring, psycho-education, and coping skills training to address specific recovery topics, and is organized into three major parts: empowerment, trauma education, and skill-building. TREM emphasizes the development of such trauma recovery skills as self-soothing, self-protection, emotional modulation and problem solving. Open trials, conducted over an 8-year period, have demonstrated decreases in psychiatric symptoms, greater interpersonal safety, enhanced overall functioning, and decreases in the utilization of intensive psychiatric services. Mueser, Rosenberg and collaborators developed and pilot tested a 12-16 session, individual intervention for post-traumatic stress disorder tailored for use with SMI clients. Cognitive restructuring is used to address thoughts and beliefs related to trauma experiences and their consequences. The 12-16 session program also includes psycho-education and breathing retraining. The results of an open trial suggested high retention rates (85%) with reductions in PTSD diagnoses (based on the Clinician Administered PTSD Scale) from 100% at baseline to 60% at post-treatment and 45% at 3-month follow-up. Clients also experienced significant reductions in the affect subscale of the BPRS (Brief Psychotic Rating Scale) from baseline to the 3-month follow-up. A randomized controlled trial of this intervention is currently underway.

21 Preventing Psychological and Moral Injury in Military Service

PMI (commun)

Monroe Ballroom, 6th Floor

Shay, Jonathan, MD, PhD, Department of Veterans Affairs Outpatient Clinic; Stokes, James, MD, United States Army Medical Corps; Kudler, Harold, MD, Duke University Medical Center; Biesold, Karl-Heinz, MD, Bundeswehr Krankenhaus, Hamburg; March, Cameron, Royal Marines Stress Trauma Project; Pierce, Jack, MD, United States Navy Bureau of Medicine and Headquarters, Marine Corps; Ritchie, Elspeth, MD, United States Army Medical Corps

TECHNICAL LEVEL: Intermediate

An informal, unofficial international exchange among military and mental health professionals on prevention and early treatment of psychological and moral injury in military service. No one will speak officially for their services or for their governments. Their remarks are their own. Attendees agree not to publish or circulate attributed quotations without permission of the person quoted; participation does not imply endorsement of remarks by other presenters. An

occupational health framework provides structure: Primary prevention: eliminate war; Secondary: redesign culture, policies, and practices to prevent and reduce injury to troops; Tertiary: early, expert, and far-forward detection, assessment, and treatment of exposures and injuries as they happen, but still within the military institutions. The specific allocation of time among specific levels of prevention, and to specific practices, policies, research overviews and needs for research, will be shaped by the mix of interests brought to the session by attendees. In past years, attendees from all over the world have made enormously valuable contributions, and air time will be provided for attendees who wish to speak at greater length than the usual conference question or comment. The presenters come to learn as well as to teach. The four active duty uniformed presenters from the US and UK may be unable to attend if deployed by their forces, but the three presenters not fitting that description will be able to present.

22 Prevention of PTSD and AIDS Risk Among High Risk Inner-City Women

PMI (clin res)

Parlor A, 6th Floor

Hobfoll, Stevan, PhD, Kent State University; Summa Health System; Suniga, Sarah, MA, Kent State University; Briggs-Phillips, Melissa, PhD, Kent State University; Stines, Lisa, MA, Kent State University; Vranceanu, Ana Maria, MA, Kent State University

TECHNICAL LEVEL: Intermediate

Participants are advised that the presentation will involve showing videotapes of women responding to strong interpersonal conflict and learning negotiation skills appropriate for conflict management.

Women in general, and inner-city women in particular, are often exposed to violence in childhood and adulthood. This exposure makes them vulnerable to both PTSD and to HIV due to the connection of violence exposure and high risk sexual behavior. We report on and illustrate a NIMH funded prevention program that has been recommended by the CDC, PASHA, and SAMSHA as a model program. The intervention is based on exposure therapy and cognitive behavioral skills training. Group leaders work with high risk women using a studio quality, interactive, video-tape based curriculum that exposes women to increasing levels of interpersonal male-female conflict and simultaneously trains them using role play and cognitive rehearsal in high order negotiation skills used by mediators. Women attend 6 sessions in order to decrease their avoidance and/or aggressive response to interpersonal conflict. They also learn how to avoid violent interactions and the limitations of interpersonal skills when a male partner is violence prone. The workshop will illustrate the use of tapes and exposure procedures to prevent and reduce PTSD symptoms and HIV and provide early results of our most recent controlled clinical trials. The presentation includes videotapes of women responding to strong interpersonal conflict and learning negotiation skills appropriate for conflict management.

23 Divided Mind, Divided Body: Structural Dissociation of the Personality

PMI (practice)

State Ballroom, 4th Floor

Nijenhuis, Ellert, PhD, Cats-Polm Institute; Ogden, Pat, PhD, Sensorimotor Psychotherapy Institute, Naropa University; Minton, Kekuni, PhD, Naropa University, Sensorimotor Psychotherapy Institute

TECHNICAL LEVEL: Intermediate

Survivors commonly present trauma-related physical symptoms, such as bodily anesthesia, analgesia, and motor inhibitions. These often-neglected somatoform dissociative symptoms can be distinguished from psychoform dissociative symptoms such as amnesia and intrusive images. Dissociative symptoms can be further classified as relating to, and alternating between, avoiding or re-experiencing the trauma. This biphasic pattern has its roots in structural dissociation of the personality, which typically develops along evolutionarily prepared psychobiological action systems. The parts of the personality involving actions systems dedicated to daily functioning attempt to avoid reminders of the trauma in order to complete life tasks, while the parts involving action systems dedicated to survival of the individual, especially under threat to bodily integrity, are fixated in traumatic memories. Treatment traditionally has been

Thursday, October 30
8:30 a.m.–12:00 p.m.
Morning (Continued)

rather exclusively directed toward the patient's cognitive and emotional functioning, and toward psychoform symptoms. However, a body-oriented approach is also indicated that addresses somatoform dissociative symptoms as manifesting in different parts of the personality. Avoidant parts tend to have negative symptoms (e.g., bodily anesthesia), but can be intruded by symptoms of trauma-fixed parts (e.g., pain, motor inhibitions). The presenters will clarify the theory of structural dissociation of the personality, and explore the treatment of trauma within a phase oriented treatment approach, using principles of Sensorimotor Psychotherapy. They will introduce body-oriented interventions that illustrate working with and integrating somatoform symptoms through role-play and excerpts of videotaped therapy sessions.

24 Traumatized Persons Who Kill: Trauma Research in Death Penalty Cases

PMI (frag)

PDR# 4, 3rd Floor

LeBoeuf, Denise, JD, Capital Post-Conviction Project of Louisiana; Foy, David, PhD, Pepperdine University; Wayland, Kathleen, PhD, Habeas Corpus Resource Center; Campbell, Marie, Self-Employed Mitigation Specialist
TECHNICAL LEVEL: Intermediate

The family histories of capital defendants reveal extreme familial, community and institutional violence over generations. Defendants typically have extensive trauma histories themselves, including neglect and maltreatment occurring at each stage of childhood development. Legally, the facts of traumatic neglect and maltreatment during childhood are admissible evidence in mitigation, as is any psychological disorder resulting from trauma. During the sentencing hearing of capital trials, capital defenders present their clients' trauma histories to the jury and need expert assistance to explain the effects of traumatic exposure and disseminate trauma research in the courtroom. Trauma experts have a critical role to play in educating the defense team, judge and jury about the extreme consequences of intergenerational violence. Trauma professionals may provide this information in a number of ways, as an evaluating expert, in an educational capacity, or as a non-testifying consultant who educates the defense team about a wide range of issues related to trauma. In some cases, the homicide is directly linked to a diagnosis of PTSD, as, for example, when the behavior during the homicide was a traumatic reenactment of earlier traumatic experiences or was clearly the result of a flashback. In other cases the connection between the homicide and the trauma history is not so direct, and the trauma expert's role is to explain the symptoms and onset of complex PTSD and its effect on perception, judgment, cognition, and general functioning. This PMI will 1) describe patterns of intergenerational violence and trauma in this unique population; 2) present the methodology (documentary evidence, interviews, and research) currently used to develop and present an intergenerational trauma history in a litigation/capital context; 3) address the range of roles that trauma experts play in educating the courts about the complex sequelae that result from extreme and protracted trauma exposure; and 4) discuss the unique legal, ethical, and clinical challenges encountered in this specialized area that intersects trauma, mental health issues and the law. This PMI includes verbal description of case material from death penalty criminal cases that some audience members may find distressing or otherwise disturbing. No graphic visual images are included in the presentation.

25 Acceptance and Commitment Therapy for PTSD

PMI (practice)

Crystal Room, 3rd Floor

Walser, Robyn, PhD, National Center for PTSD and MIRECC, VA Palo Alto Health Care System; Westrup, Darrah, PhD, National Center for PTSD, VA Palo Alto Health Care System; Rogers, David, LCSW, National Center for PTSD, VA Palo Alto Health Care System; Gregg, Jennifer, MA, VA Palo Alto Health Care System; Loew, Dorene, PhD, Anxiety Treatment Center
TECHNICAL LEVEL: Intermediate

Acceptance and Commitment Therapy (ACT) is a new model of intervention designed to address emotional avoidance while focusing on positive behavior change. An emphasis on making and keeping commitments is largely addressed in this treatment. Many individuals who are suffering with PTSD use maladaptive avoidance to escape internal experience. This avoidance can lead to problems in daily functioning and difficulty in interpersonal relationships. Many current psychotherapies for PTSD work directly to change thoughts and feelings as a means to overt behavior change. Unwanted emotion and the avoidance of painful memories and feelings are seen to be at the heart of multiple life problems and are often the target of treatment. Although this particular approach to therapy can be useful, at times acceptance of these private experiences, without efforts to control them, may be the more effective approach. This concept of acceptance as a treatment approach has long been recognized in many traditions. For instance, Client-Centered Therapy (Rogers, 1961) suggests that "openness to experience" is the predominant goal of therapy and Kabat-Zinn (1990) explains that there is no escape from the human condition and avoidance of our problems will only cause them to multiply. The solution to this dilemma is in mindfulness to experience and "owning" of each moment. Additionally, the concept of emotional avoidance may offer organization to the functional analysis of trauma-related problems and lends coherence to understanding sequelae of trauma. Many individuals who have been diagnosed with PTSD are struggling with traumatic memories, painful feelings and unwanted thoughts. Thus, the avoidance/control of internal experience commonly seems to become the goal of many trauma survivors and powerfully impacts on individuals diagnosed with PTSD. Acceptance can create a new context from which the trauma survivor may view the world and self. If efforts to control private experience are relinquished as a means to mental health, then efforts to take healthy action, without efforts to control, can lead to valued and life enhancing behavioral changes. In this pre-meeting institute, we will present the theory and application of Acceptance and Commitment Therapy as it applies to PTSD. In addition, we will demonstrate several advanced techniques of therapy. This workshop contains experiential exercises that may bring to mind personal events that are upsetting. However, no individual will be required to report on their own experience and all participation in exercises is voluntary.