

**Saturday, November 1**

**Concurrent Sessions—Saturday, November 1**

**8:30 a.m.–9:45 a.m.**

**What Is Dissociation? One Philosopher's View**

**Forum (frag) Grand Ballroom, 4th Floor**

*Braude, Stephen, PhD, University of Maryland Baltimore County; van der Kolk, Bessel, MD, Boston University School of Medicine*

It's tempting, and even reasonable, to think that dissociative phenomena point to important facts about the nature of the mind. But it's not easy to determine what those facts are. Clinicians and experimenters who consider these matters often don't realize how they import (sometimes questionable) abstract assumptions into their deliberations. As a result, the literature on dissociation offers many opportunities for conceptual clarification and analysis. This presentation will expose and analyze the assumptions underlying the concept of dissociation and then define "dissociation" in a way that allows it to be distinguished from other apparently similar concepts (e.g., repression and suppression). In the process, it will discuss apparent confusions in the debate over whether pathological dissociation is a taxon. Finally, it will consider how emphasizing the relationship between trauma and dissociation may have led to a narrow and distorted picture of the nature of dissociation. Accordingly, it will consider other avenues of research that might help broaden and clarify that picture.

**New Directions in PTSD Treatment: Integrating Outcomes and Neuroscience**

**Panel (clin res) Parlor B, 6th Floor**

*Braun, Michelle, MS, University of Wisconsin, Milwaukee; Grunert, Brad, PhD, Medical College of Wisconsin; Weis, Jo, PhD, Medical College of Wisconsin; Smucker, Mervin, PhD, Medical College of Wisconsin; Riemann, Bradley, PhD, Rogers Memorial Hospital*

Recent outcome data have shown that differential emotional reactions to PTSD events are a vital consideration in selecting the most efficacious treatment. In support of these clinical findings, neuroscience researchers have made great strides in understanding how PTSD emotions are differentially represented and changed at the level of the amygdala and the cortex. This converging evidence provides the basis for a theoretical explanation of how PTSD treatments (exposure, cognitive restructuring) differentially target specific brain areas, and helps to explain why matching PTSD emotional symptomology to treatment type is often vital to recovery. The panelists will present a recently formulated treatment algorithm for PTSD that matches, among other variables, PTSD emotional symptomology to treatment type. This algorithm, based on 20 years of clinical and research experience with vehicular and work-related accident victims, will be presented in the context of case examples and outcome data. In addition, mechanisms of neurological activation and change, based on a comprehensive review of the literature, will be discussed as they relate to the following domains of PTSD treatment: (a) brain localization of differential emotional reactions to trauma (b) therapeutic methods that are hypothesized to target abnormally functioning brain areas, and (c) new directions for PTSD treatment.

**Multi-Site Trials of Treatments for PTSD: Questions and Answers**

**Panel (clin res) Crystal Room 3rd Floor**

*Schnurr, Paula, PhD, National Center for PTSD, VA Medical Center; Foa, Edna, PhD, Center for the Treatment and Study of Anxiety, University of Pennsylvania; Krystal, John, MD, National Center for PTSD, West Haven VA Medical Center; Foa, Edna, PhD, Center for the Treatment and Study of Anxiety, University of Pennsylvania; Resick, Patricia, PhD, Center for Trauma Recovery, University of Missouri at St. Louis*

As the number of empirical investigations of treatments for PTSD has grown, there have been an increasing number of multi-site studies. These large-scale projects have many advantages, such as high statistical power and increased external validity, due to the greater variability of settings and therapists compared with a single site format. At the same time, multi-site studies also create challenges, such as how to ensure protocol adherence across multiple (and often, diverse) sites. This panel discussion intended to facilitate future multi-site research by providing participants with information about the methodological and logistic issues that arise in multi-site trials. The presentation is also intended to provide information for clinicians about how the strengths of the multi-site format can offer information that is relevant to clinical practice. The session will be chaired by Paula Schnurr, who also will discuss methodological issues. First, however, Edna Foa and Patti Resick will discuss training and supervision issues in psychotherapy studies, and then John Krystal will discuss issues specific to pharmacotherapy research. Patti Resick will discuss issues of quality control and safety. Edna Foa will synthesize the presentations and make suggestions about how to optimally design and conduct a multi-site study.

**The Ethics of Asking and Not Asking About Trauma History**

**Symposium (clin res) Adams Ballroom, 6th Floor**

*Freyd, Jennifer, PhD, University of Oregon; Newman, Elana, PhD, University of Tulsa*

Entities that evaluate ethics of trauma research (e.g., IRB's) focus primarily on potential harm to participants of asking about trauma. The potential harm of not asking about trauma, the potential benefit of gaining such information and effects on staff are often overlooked. Panelists will present data addressing these ethical issues.

**Participant Responses to Being Asked About Trauma History**

*DePrince, Anne, PhD, University of Denver; Freyd, Jennifer, PhD, University of Oregon*

Institutional Review Boards and other entities continue to raise concerns about potential harm to participants of asking about trauma history. To evaluate the cost-benefit ratio in undergraduate samples, we asked participants to respond to three questions on their experience of completing the Brief Betrayal Trauma Survey (BBTS), a 12 item behaviorally defined self-report measure. The response questions were designed to tap (1) participants' perceptions of whether the trauma history questions were more or less distressing than things encountered in day-to-day life, (2) how important participants believe it is for psychologists to ask about these types of events, and (3) how good of an idea, according to participants, it is to include such a measure in psychology research. Our data indicate that participants find on average that the BBTS is neutral compared to day-to-day experiences. Further, participants rate research asking about stressful life events as more than "somewhat important" on average. Finally, taking into account their experience of answering the questions and how important it is to ask such questions, on average participants indicate that including such measures is more than "somewhat good". Implications of these results, as well as the potential harm of excluding measures of trauma, will be discussed.

Saturday: 8:30 a.m.–9:45 a.m.

Saturday, November 1

**Student and Professionals' Reactions to Clinical and Research Activity**

*Kennedy, Shawn, The University of Tulsa; Newman, Elana, PhD, The University of Tulsa*

Although it is well documented that some clinicians who work with trauma survivors may be adversely affected by bearing witness to violence (e.g., Figley, 1995; Pearlman & Saakvitne, 1995), this reaction has not been examined among trauma-focused researchers. For safe ethical research practice, it is vital that we understand if research staff are vulnerable to any psychological harm, such as vicarious traumatization (VT), and correlates of VT. The present study uses a web-based survey to (1) examine the prevalence of VT among trauma-focused researchers and clinicians, and (2) examine how past exposure to trauma, PTSD status, and social support affect resiliency/vulnerability to VT. In knowing this, we can (a) ethically inform future researchers and clinicians about the potential risks of involvement in trauma-centered research and practice, and (b) devise training and supervision to mitigate these risks. 1,785 members of ISTSS will be invited the first week of April to participate in this study via email. Measures include the Modified Stressors Survey, PTSD Checklist, Traumatic Stress Institute Belief Scale Revision N, Personal Resource Questionnaire 2000, and the Reactions to Research Participation Questionnaire Revised. This presentation will compare clinical and research professionals' VT scores as well as look at predictors (via regression) of VT among researchers.

**Ethical Challenges of Asking and Not Asking Sex Offenders About Abuse**

*Becker Blease, Kathryn, PhD, Family Research Laboratory, University of New Hampshire; Freyd, Jennifer, PhD, University of Oregon*

Asking research participants about child abuse poses ethical and legal challenges. This presentation reviews some common IRB concerns with research on victimization and perpetration, including mandated reporting, the potential for upsetting participants, and confidentiality. In addition, the benefits of asking about abuse and the costs of not conducting this research are addressed. The reactions of convicted sex offenders participating in a survey of their experiences both with being abused and abusing others are discussed. The results of this study indicate that it is feasible to anonymously obtain data on victimization and perpetration with a high response rate. No respondents reported negative reactions to the survey. Positive reactions included direct benefits to participants (e.g. using the survey to gauge how far they had come in treatment), benefits to science (e.g. viewing participation as a way to learn more about offending), and benefits to other potential abusers and victims (e.g. the potential for research to prevent abusers from harming others). In sum, existing research, including this sex offender study, supports a favorable cost/benefit ratio for research that asks participants about abuse, although more empirical research is needed in this area.

**Motor Vehicle Accident Trauma: Coping Processes and Fragmentation**

**Symposium (disaster)**

**PDR #5, 3rd Floor**

*Benight, Charles, PhD, University of Colorado at Colorado Springs*

This symposium elucidates the coping processes following motor vehicle trauma. Ms. Midboe's paper is on appraisal of control and coping in MVA victims. Dr. Delahanty's paper focuses on coping behaviors as mediators between acute and longitudinal PTSD symptoms. Dr. Benight presents a causal model elucidating the coping process over time.

**A Test of the Goodness-of-Fit Theory in Motor Vehicle Accident Victims**

*Midboe, Amanda, MA, University of Pittsburgh Cancer Institute; Dougall, Angela, PhD, University of Pittsburgh Cancer Institute; Baum, Andrew, PhD, University of Pittsburgh Cancer Institute*

According to cognitive-phenomenological models of stress, distress results from the interplay among a stressful event, appraisal of that event, and coping skills (Lazarus & Folkman, 1984). The meaning that one assigns to a stressor is a product of primary appraisal processes, whereas judgments made about coping skills are products of secondary appraisals (Lazarus & Folkman, 1984). Consequently, an integral part of cognitive-phenomenological models of stress is matching of coping to appraisal. The ability of the goodness-of-fit theory to predict psychological distress 6 months after a motor vehicle accident (MVA) was examined in sixty-eight participants in an MVA group. Measures of coping style and appraisal of control over the MVA were taken 3 months post the MVA and psychological distress measures (depression, global severity) were taken 6 months post-MVA. Results indicate that there was partial support for the matching of appraised control and coping, as problem-focused coping was positively correlated with appraisal of control, but emotion-focused coping and control were not correlated. Results also indicated that coping alone was typically not a significant predictor of reduced distress. However, the interaction of emotion-focused coping and control predicted global severity and depression and the interaction of problem-focused coping and control predicted global severity.

**Self-Distraction, Denial, and Self-Blame Coping and PTSD Symptoms**

*Delahanty, Douglas, PhD, Kent State University; Sledjeski, Eve, MA, Kent State University; Buckley, Beth, BA, Kent State University; Raimonde, A. Jay, MD, Summa Health System; Spoonster, Eileen, RN, Summa Health System*

Relatively little research has examined whether particular coping techniques are related to PTSD symptoms or are effective at decreasing PTSD symptoms following trauma. The present study examined the extent to which self-distraction, denial, and self-blame mediated the relationship between PTSD symptoms soon after an MVA and symptoms measured 6 weeks and 3 months later. 138 male and 82 female MVA victims completed the IES-R in-hospital within 2 days of their accident. 83% of participants were white, 15% were black, and 2% reported "other" race. Currently, 140 have completed the 6-week follow-up, which included the administration of the CAPS interview and the brief COPE, and 68 have completed the IES-R at a 3-month follow-up. Self-distraction coping was significantly correlated with in-hospital IES-R scores ( $r = .45, p < .001$ ), CAPS scores at 6 weeks ( $r = .34, p < .001$ ), and IES-R scores at 3 months ( $r = .40, p < .001$ ). Similarly, the use of self-blame and denial were both related to initial ( $r = .31, .24, ps < .05$ , respectively), 6-week ( $r = .41, .36, ps < .001$ ), and 3-month PTSD symptoms ( $r = .25, .26, ps < .07$ ). However, coping styles did not mediate the relationship between initial and later PTSD symptoms, suggesting that use of "poor" coping strategies is not solely responsible for the persistence of PTSD symptoms following trauma.

**Coping with Motor Vehicle Accident Trauma: A Causal Model Analysis**

*Benight, Charles, PhD, University of Colorado at Colorado Springs; Markowski, Tina, University of Colorado at Colorado Springs; Sacks, Casey, University of Colorado at Colorado Springs; Hall, Crissy, University of Colorado at Colorado Springs*

This study tested a structural model of coping with motor vehicle trauma over time. Following admission to the ER, 183 participants were followed at 4-7 days and 30 days later. Average age was 36 (SD = 14.08). More women (62%) than men (38%) participated and median income was \$35,000 and \$40,000. Participants completed a questionnaire packet at time 1. At time 2, a questionnaire, a clinical

**Saturday, November 1**

interview, and a computer cognitive task were completed. Measures included the SCID-IV, the Peritraumatic Dissociative Experiences Questionnaire(PDES), a MVA Coping Self-Efficacy (MVACSE) measure, the Impact of Event Scale- Revised (IES-R), and the Injury Severity Score. The average ISS was 1.88, suggesting minor injuries. A structural model was tested to determine the primary variables predicting psychological adjustment. The following variables were included: current or lifetime Axis I disorder (excluding PTSD), PDES, MVACSE, and IES-R. Results strongly supported the model, Chi-square = 16.02, df = 13, p = .248, Relative fit index = .983, RMSEA = .04 (lower bound = .00, upper bound = .09). The path coefficients supported a theoretical model demonstrating the interactive role of self-regulatory factors and distress in the recovery process. Theoretical and clinical implications will be presented.

**Predictors of Treatment Outcome in PTSD**

**Symposium (clin res) Monroe Ballroom, 6th Floor**

*Creamer, Mark, PhD, University of Melbourne; Rothbaum, Barbara, PhD, Emory University*

While psychological treatments for PTSD have developed considerably in recent years, large variation in individual treatment response is apparent. This symposium integrates research from the USA, Canada, and Australia to examine the impact of personal characteristics, childhood abuse history, and treatment setting as predictors of response to cognitive behavioral interventions.

**PTSD Treatment Outcome Predictors: Exposure Therapy, EMDR and Relaxation**

*Taylor, Steven, PhD, University of British Columbia*

Several psychosocial treatments appear to be effective in treating posttraumatic stress disorder (PTSD). However, little is known about the predictors of treatment outcome. It is possible that some variables predict poor outcome for some treatments but not for others. To investigate this issue, outcome predictors were examined for three 8-session treatments: Exposure therapy (entailing prolonged imaginal and in vivo exposure), relaxation training, and eye movement desensitization and reprocessing (EMDR). Sixty people with PTSD entered and 45 completed treatment. To our knowledge, ours was the first EMDR study to meet all the Foa and Meadows Gold Standards for methodologically sound outcome research. Treatments did not differ in attrition or perceived credibility. Exposure tended to be most effective, and EMDR and relaxation did not differ in efficacy. Low patient ratings of treatment credibility (assessed in session 2) predicted treatment dropout, regardless of treatment type. Of the potential outcome predictors examined, severe reexperiencing symptoms (assessed prior to treatment) predicted poor outcome for relaxation training but not for the other therapies. The best predictor of treatment outcome was whether or not patients received exposure therapy.

**Evaluation of Differential Program Types for C-R PTSD**

*Forbes, David, MA, University of Melbourne; Creamer, Mark, PhD, University of Melbourne; Hawthorne, Graeme, PhD, University of Melbourne; Biddle, Dirk, MA, University of Melbourne*

Since 1995, the Australian Centre for Posttraumatic Mental Health (ACPMH) has accredited Veterans Affairs funded PTSD programs for veterans across the country. While there is reasonable consistency in the treatment content across programs, there is considerable variety in the way these programs are structured (low, medium and high intensity) and the settings in which they occur (inpatient, residential, outpatient and outreach regional settings). This paper examined the data for 2265 veterans treated in such programs and evaluated the relative effectiveness of the different treatment structures and settings. Initial statistical analysis suggested that there were no significant differences in outcome between program types. However, further ANOVA and effect size analyses demonstrated sig-

nificant differences in effectiveness depending on PTSD severity. Analyses demonstrated that few, if any, of the program types were effective for Mild PTSD. For Moderate PTSD, the strongest outcomes were from low intensity outpatient, and medium intensity day hospital programs. For severe PTSD, moderate intensity day hospital programs, and high intensity (residential and inpatient) programs performed the strongest. At the extreme end of the spectrum, high intensity residential programs performed best. The findings of this paper suggest potential to identify optimal program type depending on condition severity.

**Treatment Outcome: Adult Physical/Sexual Assault Vs. Child Sexual Abuse**

*Cahill, Shawn, PhD, University of Pennsylvania; Yadin, Elna, PhD, University of Pennsylvania; Hembree, Elizabeth, PhD, University of Pennsylvania; Muller, Kathryn, PsyD, University of Pennsylvania; Rauch, Sheila, PhD, University of Pennsylvania; Foa, Edna, PhD, University of Pennsylvania*

Despite strong evidence of its efficacy in the treatment of posttraumatic stress disorder (PTSD), many professionals have been reluctant to adopt prolonged exposure (PE), particularly in cases of PTSD resulting from childhood abuse. It is commonly believed that victims of childhood abuse often suffer from additional difficulties, such as deficits in affect regulation and interpersonal skills, alexithymia and dissociation, that make them poor candidates for PE. We will report analyses conducted on data from a recently completed study comparing PE with and without cognitive restructuring in the treatment of women with PTSD resulting from physical assault in adulthood, sexual assault in adulthood, or sexual assault in childhood. Results will be reported for the tolerability, safety, and efficacy of treatment utilizing measures of PTSD symptom severity, associated anxiety and depression, dissociation, and anger expression. The analyses will test the hypotheses that, compared to victims of physical and sexual assault occurring in adulthood, victims of childhood sexual abuse will (1) be less able to tolerate exposure therapy, as indicated by a greater percent of dropouts; (2) be more likely to experience symptom exacerbation, defined as a posttreatment score greater than the corresponding pretreatment score; and (3) have poorer outcome across all measures.

**Medical Traumatic Stress in Children**

**Symposium (child) State Ballroom, 4th Floor**

*Saxe, Glenn, MD, Boston University Medical Center/National Child Traumatic Stress Network; Zuckerman, Barry, MD, Boston University Medical Center*

This symposium highlights research on child traumatic stress in medical settings. We begin with presentations of ASD and PTSD in children with burn and non-burn injuries. Outcomes of an intervention program for children with cancer follow. Finally, the relevance of these findings for health and mental health practitioners are discussed.

**Parent Assessment of Child Acute Stress and Pain After Traumatic Injury**

*Baxt, Chiara, MA, Children's Hospital of Philadelphia; Kassam-Adams, Nancy, PhD, Children's Hospital of Philadelphia; Winston, Laura, MD, PhD, Children's Hospital of Philadelphia*

Parent responses in the aftermath of acute child trauma have been identified as key predictors of child PTSD, but the mechanisms of parent and child interaction after trauma are less well understood. In a prospective study of children (age 8-17) hospitalized for traffic-crash injuries, 243 children and parents were assessed within one month of injury (T1) and 177 were assessed at least four months later (T2). We compared child self-report to parent-report regarding children's ASD, PTSD, and pain severity, and calculated discrepancy scores. Parent and child reports were moderately associated: ASD severity (r = .35), PTSD severity (r = .49), T1 pain severity (r = .51), and

Saturday, November 1

T2 pain severity ( $r = .48$ ). Regression analyses showed a curvilinear relationship between T1 discrepancies in parent-child ratings and child PTSD severity at T2, such that parental under- or over-reporting of child ASD symptoms or pain was predictive of greater child PTSD severity. Parents' ability to accurately assess child distress appears to play a role in promoting child emotional recovery after traumatic injury; inaccuracy may impede parental efforts to assist child coping. Implications for early intervention with parents, to help ameliorate child posttraumatic stress after medical trauma, will be discussed.

**Family Treatment of Posttraumatic Stress in Childhood Cancer Survival**

*Kazak, Anne, PhD, The Children's Hospital of Philadelphia; Alderfer, Melissa, PhD, The Children's Hospital of Philadelphia; Streisand, Randi, PhD, The Children's Hospital of Philadelphia; Simms, Steven, PhD, The Children's Hospital of Philadelphia; Rourke, Mary, PhD, The Children's Hospital of Philadelphia; Barakat, Lamia, PhD, Drexel University; Gallagher, Paul, MS, The Children's Hospital of Philadelphia; Cnaan, Avital, PhD, The Children's Hospital of Philadelphia*

Purpose: Posttraumatic stress symptoms (PTSS) are a documented long-term consequence of childhood cancer. The Surviving Cancer Competently Intervention Program is a one-day four session intervention to reduce PTSS in adolescent cancer survivors and their families. Method: Participants in this clinical trial were 150 teen survivors, 147 mothers, and 107 fathers, randomized to the treatment (N=76) or a waitlist control condition (N=74). Outcome data are the Impact of Event Scale-Revised (IES-R) and the Posttraumatic Stress Disorder Reaction Index (PTSD-RI). Results: Significant reductions in intrusive thoughts for fathers ( $t(66)=2.3, p<.05$ ) and arousal for teen survivors ( $t(105)=3.1, p<.005$ ) were found in the treatment group. Higher dropout occurred in the treatment arm (n=29; 38%) than the control arm (n=5; 7%) and those dropping out had higher PTSS scores ( $ts>2.1, ps<.05$ ). A multiple imputation approach was used to estimate data missing due to dropout. This procedure confirmed the existing study results and showed that a significant group difference would have been found on Intrusive Thoughts for mothers ( $t(139)=2.4, p<.05$ ) had our sample been retained. Conclusions: A treatment approach integrating cognitive behavioral and family therapy approaches was successful in reducing PTSS. The differential dropout highlights the difficulties in conducting intervention research in this field.

**ASD and PTSD in Children with Burn and Non-Burn Injuries**

*Saxe, Glenn, MD, Boston University Medical Center/National Child Traumatic Stress Network; Stoddard, Frederick, MD, Shriners Burns Hospitals/Massachusetts General Hospital; Lopez, Carlos, MD, Boston University Medical Center/National Child Traumatic Stress Network; Hall, Erin, MA, Boston University Medical Center/National Child Traumatic Stress Network; Kaplow, Julie, PhD, Boston University Medical Center/National Child Traumatic Stress Network; Koenan, Karestan, PhD, Boston University Medical Center/National Child Traumatic Stress Network; Bartholomew, David, BA, Boston University Medical Center/National Child Traumatic Stress Network; King, Daniel, PhD, National Center for PTSD, Boston VA Health; King, Lynda, PhD, National Center for PTSD, Boston VA Health*

The aims of this study are to determine 1) the relationship between ASD and PTSD in children with burns or other types of injury, and 2) risk factors for ASD and PTSD in these children. 105 hospitalized children (72 with burns and 33 with non-burn injury) were assessed within 2 weeks of injury for the presence of ASD. Children were reassessed 3 months following discharge for PTSD. The assessment of risk-factors includes biological, psychological, and social variables. Thirty-one percent of children with burns and twenty-four percent with non-burn injuries met criteria for ASD. A diagnosis of ASD yielded a three-fold increased risk for PTSD. Path analysis yielded three independent pathways to PTSD; 1) a pathway from acute anxiety and pain to hypersuppression of cortisol to PTSD, 2) a pathway from

the magnitude of injury to acute dissociative symptoms to PTSD, and 3) a protective pathway mediated by the child's degree of social competence. Together these three pathways account for 51% of the variance of PTSD symptoms. These results indicate that a diagnosis of ASD predicts PTSD and that there are a variety of independent pathways leading to PTSD. These pathways may be mediated by different biological systems.

**Arousal and Human Memory for Stressful Events**

**Symposium (assess)**

**Red Lacquer Room, 4th Floor**

*Morgan III, Charles, MD, Yale University School of Medicine*

This presentation will focus on stress hormone enhancement of memory for traumatic events. The presentation will briefly review animal and human studies related to the pharmacological blockade and augmentation of fear-related emotional memories. Several studies in humans that deal with adrenergic blockade and augmentation of memory will be discussed in detail. In one study healthy subjects viewed a series of 12 slides that depicted an emotionally arousing story. One hour before viewing the slides some subjects received an adrenergic blocker, propranolol, while others received placebo. One week later subjects returned for a surprise memory testing. In a second study healthy subjects viewed the same 12 slides. Five minutes after viewing the slides some subjects received infusion of an adrenergic enhancer, yohimbine hydrochloride, while others received an infusion of placebo. The subjects in this study also returned one week later for surprise memory testing. The results of these two studies and their possible relationship to posttraumatic stress disorder, particularly the re-experiencing symptoms, will be discussed. Potential implications for treatment will also be explored. The second and third studies that will be presented will address the accuracy of eyewitness memory in active duty soldiers undergoing realistic personnel intense stress. The implications of these data for the nature of traumatic memory and for forensic issues will be discussed.

**Predicting Accuracy of Eyewitness Memory**

*Hazlett, Gary, PhD, United States Army Special Operations Command; Morgan III, Charles, MD, Yale University School of Medicine; Southwick, Steven, MD, Yale University School of Medicine*

OBJECTIVES: This study was designed to assess whether eyewitness accuracy for face recognition under conditions of high stress was significantly related to performance on a standardized, neutral test of memory for human faces when administered under non stressful conditions. METHOD: Fifty-three active duty U.S. Army personnel enrolled in military survival school training were the participants of this study. During the high stress phase of training subjects were exposed to interrogation stress. 48 hours later and under non stressful conditions, subjects were administered a standardized test designed to measure a person's ability to remember human faces (Wechsler Face Test). After completing the test, subjects were presented a serial photograph array containing "mug shot" type photographs of 10 interrogators. Subjects were asked to identify the one interrogator who had conducted their high stress interrogation during the training. RESULTS: 62% of subjects accurately identified their interrogator. A significant positive relationship was observed between performance on the Wechsler Face Test and performance on the Eyewitness task. Inaccurate eyewitnesses exhibited more false negative errors when performing the Wechsler Face Test. Receiver Operating Characteristics (ROC) curve analysis using eyewitness accuracy as the state variable and performance on the Wechsler Face Test as the trait variable indicated the area under the curve was significant. CONCLUSIONS: The present data suggest that even under "ideal conditions"-where witnesses are shown a photograph of the "perpetrator" taken at the time of the "crime,"-it is very likely that more than 1/3rd of people will be incorrect in their eyewitness identifications. These data also suggest that the trait ability to remember human faces may be related to how accurately people recall faces that are associated with highly emotional cir-



**Saturday, November 1**

**Interventions in the Child Development Community Policing Network**

*Murphy, Robert, PhD, Yale Child Study Center; Marans, Steven, PhD, Yale Child Study Center*

As first responders, police officers may influence the mental health of acutely traumatized children and adolescents through collaboration with mental health providers. In a child oriented community policing model, their traditional positions of authority and 24-hour availability are augmented by knowledge of child development and posttraumatic responses. Through the Child Development-Community Policing Program network of 12 police-mental health partnerships, mental health professionals are placed in the community, with the police, to develop collaborative strategies for intervening early when violence occurs (Marans et al., 1995; Marans, Murphy, & Berkowitz, 2002). Findings related to clinical and police service delivery highlight changes in the provision of police and mental health services to traumatized youth. Multivariate logistic regression models are presented that inform clinical decision-making about modality and timing of clinical intervention with police-involved children who are exposed to violence and other trauma (Murphy, Rosenheck & Marans, 2003). These results also highlight the multiplicity of traumatic exposure in the lives of children, as well as the role of law enforcement in ameliorating posttraumatic responses.

**Perspectives on Traumatic Grief**

**Symposium (clin res)**

**Wabash Room, 3rd Floor**

*Shear, Katherine, MD, University of Pittsburgh; Marshall, Randall, MD, Columbia University, New York State Psychiatric Institute*

Bereavement is widely recognized as a major stressor. Traumatic loss may cause symptoms of Traumatic (Complicated) Grief, a newly recognized syndrome. This symposium describes assessment and treatment models in several contexts, including war veterans, bereavement related to 9-11 and results from a randomized controlled trial of Traumatic Grief Treatment.

**Traumatic Grief Treatment: A Randomized Controlled Trial**

*Shear, Katherine, MD, University of Pittsburgh; Zuckoff, Allan, PhD, University of Pittsburgh; Frank, Ellen, PhD, University of Pittsburgh*

Traumatic Grief (TG) is a newly identified syndrome characterized by persistent intense grief with longing, yearning and preoccupying reveries about the deceased, that interfere with functioning, distressing intrusive images, and a tendency to avoid reminders of the loss. We diagnose this condition when the score on the Inventory of Complicated Grief ICG > 30. We developed a targeted Traumatic grief Treatment, (TGT), using Interpersonal Psychotherapy (IPT) and incorporating exposure strategies used in PTSD and several additional techniques. We will report preliminary results of a randomized trial comparing TGT to IPT showing TGT produces almost twice the symptom change as IPT. Randomized participants (n=67): 77% female; age 21-79; mean 47 years; 25% lost a spouse, 28% a parent, 31% a child; 36% were bereaved by a violent death; Mean baseline ICG score 46.1(SD9.5) Mean Impact of Events Score (IES) 40.3 (SD 15.0); 35% met DSM IV criteria for concurrent Major Depression and 31% for PTSD. Outcome data show decrease in ICG for both treatments with mean decrease for TGT=26.3 compared to IPT=15.8. Decrease in depression, anxiety, IES and functional impairment all are about twice as great with TGT. Study results will be presented and discussed.

**The Psychosocial Predictors and Consequences of Traumatic Loss of 9-11**

*Neria, Yuval, PhD, Columbia University and New York State Psychiatric Institute; Brett, Litz, PhD, National Center for PTSD, Behavioral Sciences Division, Boston University School; Raz, Gross, MD, MPH, Columbia University and New York State Psychiatric Institute; Marshall, Randall, MD, Columbia University and New York State Psychiatric Institute; Maguen, Shira, PhD, National Center for PTSD, Behavioral Sciences Division, Boston University School; Seirmarco, Gretchen, MS, APRN, Columbia University and New York State Psychiatric Institute*

The tragedy of Sept. 11, 2001, provided a unique and important opportunity to study individuals who have suffered loss through traumatic means, i.e., malicious mass violence. Although considered a Criterion A event, which precipitates post traumatic stress disorder (PTSD), the kind of loss incurred on 9-11 might precipitate also a complicated synergy of trauma and loss symptoms, best captured by the construct of Traumatic Grief (TG). TG, a relatively new construct, can be a particularly debilitating condition. It is based on the premise that the normal mechanism for adjustment to loss is impaired by the unpredictability, enormity, unfairness, and horrific nature of the loss. In this presentation, we describe initial findings from a web-based survey of individuals who lost loved ones, close friends or colleagues on 9-11. A number of factors that can influence the course and outcome of bereavement have are being examined, including traumatic exposure(s), attachment and coping styles, and comorbid mental illness. The study is a collaborative project of Columbia University and the New York State Psychiatric Institute-Trauma Studies and Services; and the National Center for PTSD.

**Community Grief as Observed in Project Liberty and LIFENET**

*Naturale, April, LSW, Office of Mental Health New York State*

This presentation will explore the concept of community grieving from a social theory framework, looking at multiple cultures' experiences in New York City following 9/11, and how resolution may be fostered through a broad disaster response effort. The attacks brought severe psychological distress including grief. While grief distress symptoms as a result of the loss of loved ones was immediate for some, delayed responses are still being seen. The mental health response to this disaster, as opposed to prior experience in this country, has been characterized by a continuous climb in the number of individuals accessing services with spikes seen at the 6 and 12 month anniversary periods. Eighteen months later, significant numbers of individuals accessing services for the first time, are primarily expressing complaints of anxiety, sleeplessness and fear (LIFENET) In the context of this historic disaster, anecdotal reports from provider groups indicate that the individual's they are seeing relate their trauma experiences to concerns about broad societal and cultural issues such as community trauma, collective trauma and unresolved, historical grief. This presentation will provide a theoretical framework for such responses and illustrate this with case descriptions.

## Saturday, November 1

### A Stages of Change Approach to Preventing PTSD Treatment Failure

**Workshop (practice) PDR #9, 3rd Floor**

*Murphy, Ronald, PhD, Dillard University; Rosen, Craig, PhD, Stanford University School of Medicine*

Unfortunately, PTSD patients, who often see their symptoms as adaptive, are frequently characterized as “not ready for treatment,” “resistant,” or “chronic” when they have difficulties engaging in treatment. In this workshop, presenters will first offer an integrative theory of PTSD treatment failure based on the Stages of Change (Prochaska et al.), Motivational Interviewing (W. Miller et al.) and the literatures on self-efficacy, therapeutic alliance, social class and ethnic factors as predictors of treatment outcome. In this model, readiness to change is seen as a modifiable cognitive state with specific interventions working best at different Stages of Change. Next, assessment and intervention strategies addressing causes of PTSD treatment failure specific to each Stage of Change will be reviewed. The presenters will use role-playing and other interactive formats to familiarize participants with specific techniques and skills for enhancing motivation for treatment, especially with difficult patients. These techniques include behavioral norm comparison, decision balance activities, and removal of cognitive and emotional roadblocks to acknowledging the need to change. In the last part of the workshop, participants will be asked to offer treatment failure case examples for discussion.

### Getting the Clinical Psychology Training You Want

**Workshop (train) Parlor A, 6th Floor**

*Koenen, Karestan, PhD, National Center for PTSD; Roemer, Lizabeth, PhD, University of Massachusetts, Boston; Davison, Eve, PhD, Women’s Health Sciences Division, National Center for PTSD; Grant-Knight, Wanda, PhD, Boston University Medical Center; Kilpatrick, Dean, PhD, National Crime Victims Research and Treatment Center*

Getting into graduate school in clinical psychology is very competitive and it doesn’t end there. Current graduate students must then compete for internships and post-doctoral fellowships. If you are planning to apply for graduate school, internship, or post-doctoral fellowships in clinical psychology — this workshop is for you! Current graduate faculty, internship directors, and post-doctoral program directors will provide information on how to 1) locate the best available trauma-related graduate school, internship, and post-doctoral training; 2) identify the type of training that best fits your needs; 3) put together a competitive application; 4) successfully interview; and 5) select an appropriate program. Panelists represent training programs in both child and adult clinical psychology and will address issues related to both clinical and research training. Participants should attend this workshop armed with questions about the application process.

### The Challenges of Training and Sustaining Trauma Therapists

**Workshop (practice) Parlor H, 6th Floor**

*Pearlman, Laurie, PhD, Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy LLC; Kahn, Laurie, MA, Womenscare Counseling Center; Migdow, Janet, MA, Options Counseling; Pearlman, Laurie, PhD, Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy LLC*

**Participants are advised that the presentation will involve being asked to think of a client that upsets them and privately explore their reactions.**

It is essential to attend to the development of therapists so that they do not inadvertently do harm to others, or become impaired themselves. It is no small challenge to create training programs that can translate the best of what we know about trauma, to help clinicians deepen their work and to sustain them in their work with complex trauma survivor clients. Many clinicians work in environments where the world of trauma treatment is either not understood, or even worse, viewed with skepticism or contempt. Skilled clinicians are at

risk of feeling isolated and de-skilled. We will present models for training and consultation drawing on our work in the United States and in Rwanda. These models recognize the impact of the work on the therapist, and provide opportunities for clinicians to develop a repertoire of clinical skills and perspectives. We will share from our years of experience training therapists and reflect on our mistakes and successes. Participants will be invited to join in a conversation about what makes ethical and effective trauma work possible for therapists in challenging work environments and in diverse cultural settings.

### A Case Presentation on Domestic Violence and Related Trauma

**Case Presentations (practice) PDR #4, 3rd Floor**

*Russo, Eileen, MA, University of Connecticut Health Center; Mahoney, Karen, MA, UCONN Health Center*

The case of “Isa” (a pseudonym) illustrates the application of a manualized intervention, currently in clinical trials, to address acute and chronic complex traumatic stress resulting from past maltreatment in childhood, a history of severe alcoholism, and current domestic violence. “Isa” is a mid-life Latina woman, single parent of an 8-year old daughter and in an episodically violent relationship with a live-in boyfriend of five years. “Isa” is actively in recovery from alcoholism but has replaced alcohol with excessive exercise and caretaking as a way to manage depression and anxiety. Individual therapy focused on teaching “Isa” a model of traumatic stress based on understanding how trauma biologically changes the body and brain’s normal stress response into an survival-based alarm response, and an individualized approach to helping her develop a sequence of emotion processing and self-regulation skills designed to enable her to better process and manage reactions to every-day stressors and trauma memories with a particular focus on enhancing her ability to both experience and provide secure attachment while providing effective parenting and establishing safety in her primary relationship. The presentation will highlight an approach to facilitating trauma processing that addresses complex PTSD while enhancing client self-regulation and stability psychosocially and as a parent.

### Treating Trauma in Concurrent Treatment for Addiction

*Mahoney, Karen, MA, University of Connecticut Health Center; Russo, Eileen, MA, UCONN Health Center*

This case presentation demonstrates the individual therapy application of a manualized present-focused trauma-processing therapy conducted in treatment for cocaine addiction with “Lucinda” (a pseudonym)—a 47 year old, married, African-American mother of two children (and custodian of one grandchild). “Lucinda” presented for treatment as part of a mandate by the Department of Children and Families in order not to lose custody of her grandchild. The approach used to conduct an initial evaluation including a basic screen for trauma history and PTSD symptoms will be described to illustrate the client’s and DCF worker’s concerns (e.g., destabilization and relapse) and a sensitive use of psychoeducation and alliance-building to address these concerns. After initial stabilization from cocaine use and enrollment in intensive outpatient, Lucinda had been successful with addiction recovery tasks, but had difficulty with managing her emotions (e.g., explosive anger) and alienating or frightening family members. The presentation will describe teaching “Lucinda” an individualized approach to structured self-regulation and here-and-now trauma-processing skills, including ways the caucasian clinician used the trauma recovery model to simultaneously address ethnocultural and traumatic stress factors (e.g., client distrust; importance of the extended family).

**Saturday, November 1**

**Trauma Containment in Dissociation: A Peyote Medicine Rattle**

*Mirow, Susan, PhD, MD, Associate Clinical Professor, University of Utah School of Medicine, Department of Psychiatry*

A Navajo teenager with Dissociative Identity Disorder was raped and then witnessed a double murder. She was placed in the Federal Witness Protection Program. Her amnesia to these events had persisted for several years when she became my patient. Rather than helping her to retrieve those traumatic memories, therapy was focused on guiding her to heal the damage to the sense of self that resulted from trauma. She was encouraged to live in the present and to participate in non-abusive relationships. She was provided with ego strengthening, and helped to construct a sense of self within a cultural context. Specific steps of the therapeutic process were crafted based upon her needs. One day, during treatment, she suddenly found a ritual object, a Peyote Medicine Rattle in my office. Her amnesia suddenly lifted while she gazed at the rattle, and she recounted the details of that night. Using the rattle she was able to contain, and then to re-contextualize her traumatic memories, and to accept them as personal history. Her memories, although repressed for several years, were detailed and complete. Their accuracy was corroborated by the FBI investigation. Discussion of this case includes issues regarding accuracy of memory and the focus of treatment, as well as the use of the survivor's creative process for healing.

**Witness to Sibling Homicide**

**Case Presentations (child) PDR #8, 3rd Floor**

*Koverola, Catherine, PhD, University of Maryland*

This presentation will address clinical issues in the treatment of young children who witness the homicide of a sibling by their mother's partner. The presenter will draw upon two specific clinical cases studies. Prominent themes include: (1) child's role in providing an account of what happened; (2) child's understanding of what caused the death, (e.g. young children often do not understand that the physical blows that occurred days earlier resulted in the death of their sibling); (3) child's grief process; (4) child's relationship with the mother, in particular addressing the child's feelings about the mother having failed to protect the deceased sibling; and finally (5) the process of how the child moves on to normative developmental issues. The presentation will highlight the complex role of the therapist in advocating for the child's needs through both the criminal and juvenile court proceedings.

**The Psychological Impact of War on Children: The Case of Uganda**

*Kamya, Hugo, PhD, Boston College*

In many parts of Africa and around the world, children are targets and perpetrators of war. Children experience torture, loss and are often caught fighting on various sides of different conflicts. These children suffer several forms of exploitation. They serve as laborers, sex slaves and often are involved in ritualistic abuse. They often carry out killings at the bequest of adults. All these experiences not only alienate them from others but also internally create isolation from their own psychic integrity. This presentation will discuss the vicissitudes of children caught in armed conflicts and the psychiatric sequelae as well as attempts to address these symptoms in the context of community, regional, national and international arenas. A clinical case of displaced Sudanese/Ugandan children will be used to illustrate these issues.

**Parallel Plenary Session**

**10:00 a.m.–11:15 a.m.**

**Stories of Healing and Resilience:  
The Power of Culture and Community**

**Plenary (frag) Grand Ballroom, 4th Floor**

*Munroe, James, EdD, Boston VA Outpatient Clinic; Friedman, Merle, PhD, South African Institute for Traumatic Stress Studies*

The world is continuously confronted by massive traumatic events including war, famine, genocide, terrorist attacks, and natural disasters. These events fragment local communities. In many areas, the formal structures to respond may be very limited or those resources that do exist are overwhelmed. The trauma field has developed excellent models and programs to respond to such events on a large scale, but each of these events has profound effects on a local level. It is at this local level that the healing powers of the culture and community are most important. Integration ultimately depends on drawing on the strengths of those communities that have experienced the events. This plenary session is an outgrowth of some previous ISTSS panels. It will feature story tellers from different parts of the world who will describe interventions that reflect the unique approaches to healing that are created on the local level despite overwhelming obstacles. A panel discussion will be held following the plenary session for story tellers to elaborate and answer questions. Participants will be encouraged to share their own stories of healing and resilience during the panel discussion.

**Back from the Future (Does where we have been tell us anything about where we are going?)**

**Plenary (frag) Red Lacquer Room, 4th Floor**

*Putnam, Frank, MD, Cincinnati Children's Hospital*

Does where we have been tell us anything about where we are going? Perhaps. If trends hold, some predictions are possible. We have grown more multidisciplinary, and broadened our understanding of what must be accounted for. We are moving towards more interdisciplinary team approaches to clinical, scientific, and public health problems. We have found some interesting points of cleavage allowing us to begin to dissect these problems "at their joints." The intersection of PTSD and pathological dissociation is proving a particularly fruitful plane upon which to parse the trauma response. Multi-axial and longitudinal characterizations of clinical outcomes are proving essential to our understanding. Increasingly we are able to adopt new scientific tools and clinical standards as our own. But change—no matter how beneficial—creates tensions. As the field grows broader, deeper, and more esoteric, how do organizations such as the ISTSS and ISSD remain relevant? To what extent will emerging subfields, e.g., developmental, cognitive, and neurobiologic traumatology, demand their own venues and thus reverse the trend toward integration? Our abilities to prognosticate are, of course, limited, but some trends are robust enough to extrapolate and see where they may take us.

**Saturday, November 1**

**1:00 p.m.–2:15 p.m.**

**Sensorimotor Psychotherapy**

**Master (practice) Wabash Room, 3rd Floor**

*Ogden, Pat, PhD, Sensorimotor Psychotherapy Institute, Naropa University*

Sensorimotor Psychotherapy integrates cognitive and somatic interventions in the treatment of trauma, emphasizing body awareness, practicing new actions and building somatic resources. I will demonstrate this approach through videotaped excerpts of sessions with clients, rather than role-play, so that the audience can observe the nuances of movement and watch how the body changes during therapy with real-life issues. Key components of Sensorimotor Psychotherapy will be illustrated: uncoupling trauma-based emotions from body sensations; promoting collaboration between client and therapist; teaching mindfulness; building somatic resources; and developing a somatic sense of self. Since clients with complex trauma can be easily triggered by interventions that access the body too quickly, attention will be given to pacing, boundaries, and safe, gradual re-connection with the body. The videotapes show how to help clients discover and describe how past traumatic experiences are affecting their current bodily experience—which in turn contributes to difficult emotions and beliefs—and also show how to integrate cognitive and somatic interventions to change the meaning of traumatic event(s) and regulate both emotions and arousal. Sensorimotor Psychotherapy is conducted within a phase-oriented treatment approach and this presentation will address interventions for all three phases: stabilization and symptom reduction, work with traumatic memory, and re-integration.

**Research to Guide New York City's Services for Children After 9-11**

**Panel (disaster) PDR #9, 3rd Floor**

*Rosen, Craig, PhD, National Center for PTSD; Cohen, Michael, PhD, Michael Cohen Group; Gregorian, Nellie, MS, Michael Cohen Group; Josephson, Louis, PhD, New York City Department of Health and Mental Hygiene*

This panel discusses applied research that informed New York City's efforts to help children recover from psychological stress following the 9-11 terrorist attacks. Nellie Gregorian, Partner at the Michael Cohen Group, will present results of a FEMA-funded epidemiological study of over 8,000 New York City children following the 9-11 disaster. This study, sponsored by the New York City Department of Education and conducted in conjunction with colleagues at Columbia University with sampling input from the Centers for Disease Control, informed the City's intervention planning. Dr. Louis Josephson, Assistant Commissioner for Child and Adolescent Services at the NYC Department of Health and Mental Hygiene, will discuss Project Liberty initiatives to actively screen New York children and adolescents and to provide intermediate level mental health interventions to those who continue to suffer from traumatic stress reactions. Dr. Michael Cohen, President of the Michael Cohen Group and advisor to the New York University Trauma and Media Project, will discuss how Mayor Giuliani used mass media communications to support New Yorker's resilience and positive coping. Dr. Craig Rosen, a researcher at the VA National Center for PTSD and Assistant Professor of Psychiatry and Behavioral Sciences at Stanford University, will be chair and discussant.

**Does Psychotherapy Change the Brain? Presentation and Discussion**

**Panel (clin res) Adams Ballroom, 6th Floor**

*Kimble, Matthew, PhD, University of Wales; Schwartz, Jeffrey, MD, University of California Los Angeles Department of Psychiatry; Rothbaum, Barbara, PhD, Emory University School of Medicine, Department of Psychiatry; Resick, Patricia, PhD, University of Missouri, St. Louis, Department of Psychology; Brewin, Chris, PhD, University College London, Department of Clinical Health Psychology*

While there has been considerable discussion in recent years about how stress and trauma change the brain, there has been less emphasis on how psychotherapeutic approaches may remediate such changes. This Panel Discussion, designed to bring together individuals inside and outside the field of trauma, will start with brief presentations by Dr. Jeffrey Schwartz, Dr. Barbara Rothbaum, and Dr. Patricia Resick on data, research approaches, or models relevant to how the brain changes as a result of psychotherapy. Dr. Schwartz's model of change resulted from his work showing normalization of glucose metabolism after successful CBT treatment for patients with OCD. His model emphasizes the importance of self-directed shifts in the quality of one's attentional perspective that results in systematic cerebral changes. Dr. Rothbaum will discuss her ongoing study using PET before and after prolonged exposure in female sexual assault survivors. Dr. Resick will discuss preliminary work investigating cortisol levels pre and post treatment. The presentations will be brief to allow for discussion which will be initiated by Professor Chris Brewin. The discussion will be focused on integrating findings in the areas of neuroscience and therapy, and discussing research designs best able to further our understanding of this topic.

**Treatment of Trauma in Refugees: Systems Integration**

**Panel (commun) PDR #8, 3rd Floor**

*Buwalda, Johanna (Hans), MEd, MA, Chicago Health Outreach, International FACES; Affey, Hussein, Heartland Alliance International Refugee Center; Langendorf, Trudi, Heartland Alliance International Refugee Center; Szydel, Kari, Heartland Alliance International Refugee Center; Falk, Tamara, RN, Chicago Health Outreach HIV Refugee Resettlement Program*

Refugees who come to Chicago have experienced many traumatic events during their flight, their stay in camps, and during resettlement in their new country. Many need mental health services to cope with the effects of these experiences. However, they also have many other needs related to housing, English language, family issues, education, and general and complex health care, that have to be addressed before or consecutively with mental health services. Very often, different service agencies provide services for only part of the adjustment difficulties refugees need to resolve to fully adjust to their new lives. This panel will present how various systems can be integrated, and how this systems integration is crucial to treatment of trauma in refugees.

**A Multisite Treatment Study for PTSD in Sexually Abused Children**

**Panel (child) Monroe Ballroom, 6th Floor**

*Cohen, Judith, MD, Allegheny General Hospital; Mannarino, Anthony, PhD, Allegheny General Hospital; Deblinger, Esther, PhD, University Medicine & Dentistry of New Jersey; Robert, Steer, EdD, University Medicine & Dentistry of New Jersey*

This workshop will describe the design, two alternative treatment modalities (trauma-focused CBT (CBT) and Child-centered supportive therapy (CST)) and initial results of the first multi-site randomized controlled treatment study for sexually abused children with Posttraumatic Stress Disorder (PTSD) symptomatology. Of 229 children assessed and admitted into the study at two treatment sites, 203 (88%) attended at least three treatment sessions and completed post-treatment assessments. These children and their non-offending parent or primary caretaker were randomly assigned to one of two manualized treatment conditions (CBT or CST). Treatment con-

Saturday: 1:00 p.m.–2:15 p.m.

**Saturday, November 1**

sisted of 12 sessions provided individually to parents and children; in the CBT session, 3 of these sessions also included joint parent-child interventions. The following instruments were completed by the child at pre- and post-treatment: K-SADS-PTSD, Children's Depression Inventory (CDI), State-Trait Anxiety Inventory for Children (STAIC), Children's Shame Questionnaire (CSQ) and the Children's Attribution & Perception Scale (CAPS); parents completed the K-SADS-PTSD, the Child Behavior Checklist (CBCL), Parent's Emotional Reaction Questionnaire (PERQ), Child Sexual Behavior Inventory (CSBI), Parenting Practices Questionnaire (PPQ), Parental Support Questionnaire (PSQ), and the Beck Depression Inventory (BDI). Using ANCOVAs, adjusted mean squares were compared and effect size was calculated after controlling for pretest scores. Results indicated that on all 3 K-SADS-PTSD clusters, CBCL Total scale, CDI, CAPS credibility and interpersonal trust subscales, CSQ, BDI and PERQ, scores improved significantly more in the CBT group than in the CST group. Effect sizes were medium or large for all of these. Multiple Imputation (intent to treat) analyses revealed a similar pattern of findings. Clinical significance and future research directions will be discussed.

**An Update on the Biology of Dissociation**

**Symposium (biomed) Red Lacquer Room, 4th Floor**

*Simeon, Daphne, MD, Mount Sinai School of Medicine; Putnam, Frank, MD, Mayerson Center for Safe and Healthy Children*

The symposium will present and discuss recent neurobiological findings in dissociation: 1) fMRI functional connectivity data in PTSD subjects during dissociative versus flashback states; 2) Cortisol data under rest, dexamethasone suppression, and psychosocial stress in chronically depersonalization disorder subjects; 3) structural MRI and cortisol data in dissociative identity disorder.

**Flashback and Dissociative Responses in PTSD: fMRI Functional Connect**

*Lanius, Ruth, MD, PhD, The University of Western Ontario; Williamson, Peter, The University of Western Ontario; Boksmann, Kristine, The University of Western Ontario; Densmore, Maria, The University of Western Ontario; Neufeld, Richard, The University of Western Ontario; Gati, Joseph, Roberts Research Institute; Menon, Ravi, Roberts Research Institute*

Pilot studies in our laboratory have shown that Posttraumatic Stress Disorder (PTSD) patients can have distinctly different responses to traumatic script-driven imagery. Some patients relived their traumatic experience through flashbacks and showed an increase in heart rate, other patients reported a dissociative response with no concomitant increase in heart rate in most cases. Traumatic memory recall in PTSD was studied using the traumatic script-driven symptom provocation paradigm adapted to functional magnetic resonance imaging (fMRI) at a 4 Tesla field strength in 28 subjects with PTSD and 22 control subjects. Psychophysiological interactions (PPI) analyses were used to examine functional connectivity during script-driven imagery-induced reliving and dissociative states. PTSD subjects with a reliving response to the traumatic script-driven imagery showed significantly less activation of the thalamus, the anterior cingulate gyrus (area 32), and the medial frontal gyrus (area 11) as compared to controls. PTSD patients in a dissociative state showed more activation in the superior and middle temporal gyri (BA 38), the inferior frontal gyrus (BA 47), the occipital lobe (BA 19), the parietal lobe (BA 7), the medial frontal gyrus (BA 10), the medial cortex (BA 9), and the anterior cingulate gyrus (BA 24 and 32) as compared to controls. These findings suggest different patterns of brain activation and functional connectivity in flashback versus dissociative responses to traumatic script-driven imagery.

**HPA Axis Under Rest and Stress in Chronic Depersonalization**

*Simeon, Daphne, MD, Mount Sinai School of Medicine; Knutelska, Margaret, MPhil, Mount Sinai School of Medicine; Nelson, Dorothy, Mount Sinai School of Medicine; Yehuda, Rachel, PhD, Mount Sinai School of Medicine; Putnam, Frank, MD, Mayerson Center for Safe and Healthy Children; Schmeidler, James, PhD, Mount Sinai School of Medicine*

The presentation will focus on preliminary findings from an ongoing study of hypothalamic-pituitary-adrenal axis function in chronic dissociation without PTSD. Twenty subjects with depersonalization disorder (DPD) and 18 healthy comparison subjects (HC) have been analyzed to date. Under baseline rest conditions, there were no group differences in 24-hour urinary cortisol level or in serial hourly 8 a.m.- 11 p.m. plasma cortisol levels. However, the dissociative group exhibited trend significant resistance to low-dose dexamethasone challenge compared to the healthy group, replicating previous pilot findings. In response to a psychosocial stress paradigm, the two groups demonstrated a comparable absolute surge in plasma cortisol, despite the significantly greater subjective distress of the DPD group. This was accounted for by a positive correlation between distress and cortisol surge in the HC group versus a negative correlation in the DPD group. In summary, these preliminary data are suggestive of HPA axis dysregulation under chemical and psychosocial stress in chronic dissociation unaccompanied by PTSD.

**Neurobiological Correlates of DID, in Comparison with PTSD AD BPD**

*Vermetten, Eric, MD, PhD, University Medical Center/Central Military Hospital; Schmahl, Christian, MD, Department Psychiatry, University Freiburg; Wilson, Kristen, MA, Sheppard Pratt Health System; Zdunek, Cheryl, MA, Sheppard Pratt Health System; Loewenstein, Richard, MD, Sheppard Pratt Health System; Payne, Cynthia, MD, Greater Baltimore Medical Center; Bremner, J., MD, Department of Psychiatry and Behavioral Science, Emory University*

Objective: The neurobiological profile of dissociative identity disorder (DID) is not well known. It's clinical profile is characterized by symptoms of identity alteration with inability to recall important personal information. Surveys have demonstrated that the majority of patients with DID have given accounts of early childhood trauma and meet criteria for comorbid PTSD. The construct validity of DID has been described as a form of chronic PTSD. We examined cognitive and neurobiological correlates of DID and compared them with the neurobiological profile known in chronic PTSD and Borderline Personality disorder (BPD). Method: We assessed clinical and cognitive (memory related) parameters, stress related neurobiological parameters and performed MRI in a female population of patients with DID (n=16), PTSD (n=15) and BPD (n=10). Results: Except for clinical psychiatric parameters, on most of the parameters that were assessed (memory-related, urinary cortisol, and hippocampal volume), DID subjects were not significantly different from non-DID PTSD subjects or BPD. Subtle trends were elevated morning plasma cortisol levels in DID, and some DID patients showed suppression to low dose DST. Conclusion: While DID and PTSD to certain extent BPD have strong overlapping baseline cognitive and neurobiological profiles, there are subtle differences that merit further investigation.

## Saturday, November 1

### Recent Developments in Clinical Research on Complex PTSD I: Assessment

Symposium (clin res)

Grand Ballroom, 4th Floor

#### Featured Symposium

*Spinazzola, Joseph, PhD, The Trauma Center, Boston University School of Medicine; van der Kolk, Bessel, MD, The Trauma Center, Boston University School of Medicine*

This symposium continues a 4-year initiative to present leading applied clinical research on the complexities of adaptation to trauma. Presentations address transcultural and culture-specific prediction of DESNOS; prevalence of complex trauma exposure and outcomes across a multisite U.S. child/adolescent sample; and methodological advances in complex trauma assessment and treatment planning.

#### Complex Trauma in the National Child Traumatic Stress Network

*Spinazzola, Joseph, PhD, The Trauma Center, Boston University School of Medicine; Ford, Julian, PhD, University of Connecticut School of Medicine; van der Kolk, Bessel, MD, The Trauma Center, Boston University School of Medicine; Blaustein, Margaret, PhD, The Trauma Center, Boston University School of Medicine; Brymer, Melissa, PsyD, National Center for Child Traumatic Stress, UCLA; Cook, Alexandra, PhD, The Trauma Center, Massachusetts Mental Health Institute; Silva, Susan, PhD, Duke University Medical Center*

The National Child Traumatic Stress Network (NCTSN) is a 37-site organization serving over 150,000 traumatized children and their families in 19 states. From its inaugural meeting in February 2002, a consensus emerged that exposure to chronic/multiple traumas and manifestation of complex associated sequelae are predominant components of the developmental histories and presenting complaints of a substantial portion of children and adolescents served by this network. In response, a taskforce was developed to increase network and national understanding of the impact of complex trauma on children. This presentation describes results of a survey assessing the scope of complex trauma exposure and symptomatology across the array of service settings represented by this network, as well as the effectiveness of current treatment practices. Data will consist of aggregate client information from a representative sampling of clinicians from over 30 network sites. Sampled clinicians were chosen blind to the focus of this survey and were selected based on provision of direct clinical services to a minimum caseload of 10 traumatized children during 2002. The final sample is estimated to include data from approximately 90 clinicians on over 1000 children. The presentation will discuss future directions in the assessment and treatment of child complex trauma in light of survey findings.

#### Child and Adolescent Needs and Strengths: A Child Trauma Assessment Tool

*Kisiel, Cassandra, PhD, The Trauma Center, Massachusetts Mental Health Institute; Blaustein, Margaret, PhD, The Trauma Center, Boston University School of Medicine; Walsh, Kate, The Trauma Center, Boston University; Spinazzola, Joseph, PhD, The Trauma Center, Boston University School of Medicine; van der Kolk, Bessel, MD, The Trauma Center, Boston University School of Medicine*

A key part of understanding and addressing the needs of traumatized children is identification and assessment. The Child and Adolescent Needs and Strengths—Trauma Exposure and Adaptation (CANS-TEA) is an assessment tool designed with three overall purposes: 1) to document the range of symptoms, risk behaviors, and strengths exhibited by traumatized children; 2) to describe the contextual factors and systems that can support a child's adaptation from trauma, and; 3) to assist in the management and planning of services for traumatized children. The CANS-TEA provides a structured assessment of children exposed to trauma along a set of dimensions relevant to treatment decision-making. It is designed to be used either as a prospective assessment tool for

decision support during the process of planning services or as a retrospective assessment tool based on review of existing information for use in the design of high quality systems of services. Preliminary results will be presented from a study conducted at the Trauma Center in Boston to demonstrate how the CANS-TEA is a flexible assessment tool that can be useful in integrating information from multiple sources, planning treatment, and monitoring outcomes. The CANS-TEA will also discuss in terms of its usage as a training tool.

#### Transcultural Predictors of Disorders of Extreme Stress (DESNOS)

*de Jong, Joop, MD, PhD, Transcultural Psychosocial Organization (TPO) and Vrije University; Spinazzola, Joseph, PhD, The Trauma Center, Boston University School of Medicine; van der Kolk, Bessel, MD, The Trauma Center, Boston University School of Medicine; Komproe, Ivan, PhD, Transcultural Psychosocial Organization and Vrije University; Blaustein, Margaret, PhD, The Trauma Center, Boston University School of Medicine; van Ommeren, Mark, PhD, Transcultural Psychosocial Organization (TPO) and Center for Victims of Torture*

The symptom clusters constituting Disorders of Extreme Stress (DESNOS) have been identified in non-western cultures and found to be comorbid with DSM-IV disorders (de Jong, et. al., under review). In follow-up to data presented at last year's conference, the current study examines trauma-specific factors in transcultural and culture-specific prediction of DESNOS. A total of 3048 study participants were randomly selected from four post-conflict countries representing different regions of the world: North Africa (Algeria), East Africa (Ethiopia), Southeast Asia (Cambodia), and the Middle East (Gaza). Participants were these evaluated for lifetime history of trauma exposure, PTSD and DESNOS. Overall prevalence of DESNOS ranged from 2–13%, with substantially higher prevalence of the six individual DESNOS symptom clusters: Affect Dysregulation (13–25%); Dissociation (23–56%); Somatization (12–54%); and Alterations in Self-Perception (15–31%), Relations with Others (25–66%) and Systems of Meaning (28–65%). Statistical models will test the predictive relationship of trauma-exposure characteristics—including trauma type, onset, duration and number-on DESNOS outcomes within and across cultures studied. Findings will be discussed within the context of a phenomenological model of extreme stress response that posits and tests the presence of (a) universal versus culture-specific underlying processes of disturbance; and (b) associated transcultural versus culture-specific symptom expression.

#### Models of Mental Health Services for Refugee Children

Symposium (culture)

PDR #4, 3rd Floor

##### Endorsed by the Diversity and Cultural Special Interest Group

*Birman, Dina, PhD, University of Illinois at Chicago and National Child Traumatic Stress Network*

Four presentations will describe different treatment approaches used with traumatized refugee children by representatives of three sites within the National Child Traumatic Stress Network. The first presentation will outline different paradigms of service in the refugee mental health field, and then each of the sites will describe their unique approach.

#### The Intercultural Child Traumatic Stress Center of Oregon

*Kinzie, David, MD, Department of Psychiatry, Oregon Health Sciences University*

The Intercultural Child Traumatic Stress Center of Oregon targets the most impaired refugee and immigrant children, with special emphasis on Spanish speaking and Vietnamese. We outreach to schools and refugee groups and accept referrals of children who meet some criteria of traumatic experience. We use our bilingual counselors to gather information and serve as interpreters for the child psychiatrist. The assessment and treatment are done by the psychiatrists in the clinic. This "medical" approach identifies the

**Saturday, November 1**

most impaired and disturbing children of parents, counselors and teachers. Our clinical experience confirms the severity of the cases and indicates that clinical presentations differs much from the community approaches. There are 3 main types of patients treated: (1) those that have suffered the direct effect of trauma; (2) those whose parents have suffered and the children have the indirect effects often related to poor parenting; and (3) those whose families have endured trauma but on evaluation the child's clinical symptoms are unrelated to trauma, i.e. mental retardation or early psychosis. We will present data and case histories demonstrating these points.

**International FACES: Framing Culture and Family**

*Batia, Karen, PhD, Chicago Health Outreach and National Child Traumatic Stress Network*

Chicago Health Outreach's International FACES provides comprehensive, community-based mental health services for traumatized refugee, asylee and asylum seeking children and their families who have experienced the trauma of war and displacement. Chicago Health Outreach (CHO) is the health care partner of Heartland Alliance for Human Needs & Human Rights, formerly Travelers & Immigrants Aid. Tracing its roots to the Jane Addams Hull House movement, Heartland Alliance has worked since 1888 with the most impoverished and vulnerable residents of Chicago. A variety of services including: case management, individual and group psychotherapy, art therapy, occupational therapy, and psychiatric assessment and treatment are provided by a multidisciplinary treatment team often refugees themselves and trained interpreters. Services are provided in the community, on-site at schools and in participants' homes. Clinical work is based on providing holistic care within the context of the culture and values of the family and refugee community. In addition, International FACES provides community services including outreach and engagement into services, stigma reduction, consultation, education and training, and advocacy.

**Conceptual Underpinnings of Treatments for Refugee Children**

*Birman, Dina, PhD, University of Illinois at Chicago and National Child Traumatic Stress Network; Jones, Curtis, MA, University of Illinois at Chicago; Pulley, Emily, MPA, University of Illinois at Chicago; Basu, Archana, MA, Heartland Alliance for Human Rights and Human Needs, International FACES Program*

The field of refugee mental health has been gaining increasing attention as world crises continue to create large refugee flows (Marsella et al., 1994). With respect to refugee children, a large body of research has documented that refugee children exhibit symptoms of PTSD at alarmingly high rates, as high as 75% in community samples in some studies (Allwood, et al., 2002). In addition to traumatic stress, refugee children experience acculturative stress (c.f. Berry, 1994; 1998, Birman & Trickett 2001) as well stresses associated with migration and displacement. However, few of these children receive services for a number of reasons such as stigma associated with seeking mental health care and lack of sufficient resources within the U.S. mental health system to provide easily accessible and culturally competent services. This presentation will describe the context within which the U.S. refugee mental health field emerged and outline the development of treatment approaches in the field. Conceptual frameworks that shape understanding of the problems and treatment approaches for refugee children will be offered to consider the commonalities and differences of those described in the three presentations that will follow. These frameworks will help facilitate a discussion of improving mental health services for refugee children.

**An Integrated Approach to Treating Refugee Children and Their Families**

*Grant-Knight, Wanda, PhD, Boston University School of Medicine*

The Center for Medical and Refugee Trauma in the Department of Child and Adolescent Psychiatry at Boston Medical Center/Boston University School of Medicine is devoted to the development of new treatments for children and families who have experienced war, displacement and resettlement stress. This presenter will outline an integrated treatment approach the Center has been developing that informs the conceptualization of work with these children and their families. This approach, *Neurons to Neighborhoods*, is based on the assumption that the most effective interventions for children must be built upon a solid scientific foundation of child development. Accordingly, this model integrates the most recent understandings about: 1) the dynamic relationship between brain and environment; 2) the critical role of social context for child development; 3) the primacy of relationships for the developing child; 4) the ongoing dynamic interplay between sources of risk and resilience across all levels of the social environment (i.e., individual, family, school, peer group, and neighborhood) and the need to intervene across these multiple levels; and 5) an appreciation of the need to view the assessment and intervention process through a cultural lens that will inform clinical work and engage families to overcome treatment barriers.

**Complex Sequelae of Disorganized Attachment and Unresolved Trauma**

**Symposium (child)**

**State Ballroom, 4th Floor**

**Featured Symposium**

*Stovall-McClough, Chase, PhD, New York University School of Medicine, New York University Child Study Center, Institute for Trauma and Stress; Lieberman, Alicia, PhD, University of California, San Francisco*

This symposium brings together three studies that examine the consequences of unresolved childhood trauma for later psychopathology and interpersonal functioning from an attachment perspective. The symposium moves from a focus on infant attachment disorganization and adolescent dissociative symptoms, to two studies of adults with unresolved attachment states of mind.

**Disorganized Attachment, Borderline Traits and Child Abuse Potential**

*Alexander, Pamela, PhD, Albert Einstein Healthcare Network*

Disorganized attachment is known to be associated with a history of abuse (Carlson, Cicchetti, Barnett, & Braunwald, 1989), with parent-child role reversal and dissociation (Liotti, 1992), with the development of borderline personality traits (Fonagy, 1999), and with later controlling and aggressive behavior (Main & Cassidy, 1988). Moreover, problems with or distance from both parents are required in order for the child to need to depend on the abusive parent as the primary attachment figure (Anderson & Alexander, 1996). A presentation based on this model of intergenerational transmission of abuse is tested in a sample of mothers and fathers participating in the Marines' New Parent Support Program (a home-visitation child abuse prevention program). Child abuse potential in both genders is indeed associated with a history of abuse (especially sexual abuse), with distance from both parents, with current borderline personality traits, with fearful or preoccupied attachment, with marital distress and conflict, with problems in affect regulation, with dissociation and with role reversal with one's own child. Implications for theory and treatment are described.

**Saturday, November 1**

**Disorganized Attachment and the Relational Context of Dissociation**

*Lyons-Ruth, Karlen, PhD, Harvard Medical School*

While dissociation has been related to severe and chronic abuse, many traumatic events do not result in serious symptomatology. A model of fear regulation based on attachment theory would suggest that the impact of traumatic experiences is partially buffered by the quality of comfort and security available in primary attachment relationships or is exacerbated by relational processes that contribute to maintaining dissociation of mental contents. Two 20-year longitudinal attachment studies of families at social risk have now followed their cohorts of infants to late adolescence, one at the University of Minnesota and in our own lab. Several key findings have emerged related to outcomes of interest to the study of trauma. First, data from both studies indicate that disorganized attachment behaviors in infancy are important precursors to later dissociative symptomatology. Second, this early vulnerability is related to patterns of parent-infant affective communication, particularly “quieter” behaviors like emotional unavailability or role reversal, and does not appear to reside in the infant alone. Severity, chronicity, and age of onset of trauma do not account for as much variance in adolescent dissociative symptoms as do early caregiving and attachment status. The results suggest that the quality of the attachment relationship may partially account for why some people exposed to later trauma develop dissociative symptoms and others do not.

**Unresolved Trauma and CA-Related PTSD in Treatment-Seeking Women**

*Stovall-McClough, Chase, PhD, New York University Child Study Center; Cloitre, Marylene, PhD, New York University Child Study Center*

Both the trauma and attachment literatures suggest that when childhood abuse occurs in the context of insensitive or chaotic caregiving, aspects of traumatic experiences may be left unevaluated and unintegrated in memory. A failure to complete a process of mental reorganization following at traumatic event is thought to underlie both the development of PTSD and the uniquely incoherent speech seen in the Adult Attachment Interview by those classified as Unresolved. The link between unresolved attachment and PTSD is important because several studies have demonstrated that adults who are classified as Unresolved with regard to trauma are likely to develop Disorganized attachment relationships with their infants (van Ijzendoorn et al., 1995), thus promoting the intergenerational transmission of trauma. In the first study presented, we examined rates of Unresolved attachment among treatment-seeking women with histories of childhood abuse with PTSD, borderline personality disorder, and neither disorder. Data indicate that women with histories of abuse with PTSD and BPD can be distinguished from women without trauma-related diagnoses on the basis of their classifications on the AAI. In the second study, we present preliminary data on change in attachment states of mind following two cognitive-behavioral treatments for CA-related PTSD (skills training versus exposure).

**Race, Ethnicity and Trauma: Treatment, Education and Policy**

**Symposium (culture) Crystal Room, 3rd Floor**

**Endorsed by the Diversity and Cultural Special Interest Group**

*Webb, Earnest, PhD, MSW, PC, Private Practice; Armstead, Ron, MCP, Congressional Black Caucus Veterans Braintrust*

Presenters will discuss racial and ethnic perspectives focusing on incidence, etiologies and treatment options for PTSD in the wake of war, terrorism, community violence, child abuse and neglect in the minority community. In addition, to a unique Howard University Center for Drug Abuse Research sponsored multi-disciplinary conference approach for enhancing culturally competent treatment, and/or effective cross-cultural counseling techniques.

**Community Violence, Terror from Within**

*Poag, Clyde, MSW, Rational Training Consultants*

For eighteen years I provided clinical services to Vietnam veterans in an urban Vet Center located in Grand Rapids, Michigan, and am presently working in Detroit, as Clinical Director of a large social service agency. In these capacities, I have witnessed the ravages of urban violence and trauma. As one of many urban clinicians who are being bombarded with sociological problems such as crack, heroin, legal and illegal drug use, depression, suicide attempts and overdoses, and child abuse and neglect. For us the urban community setting has taken on the trappings of a war zone. With African Americans seeking clinical services at the mercy of euro-centric interpretations, or labels, without the benefit of research, which presents an accurate picture of African American family life, cultural strengths, and resiliency. Clinicians and clients alike are often placed under enormous pressure to navigate African American and Anglo-American cross-cultural differences. With many clinicians advocating the need for more effective counseling techniques that offer self-help, cross-cultural, and non-judgmental treatment approaches. Rational Behavior Therapy (RBT) as formulated by Dr. Maxie Maultsby is such an approach. It is a self-counseling approach, which teaches people to counsel themselves.

**Howard University, African Americans and PTSD: A Retrospective**

*Bailey, Ura Jean Oyemade, PhD, Center for Drug Abuse Research, Howard University*

The Howard University African American Conferences on PTSD continued the visionary work started in the early/mid 80s by the Black Veterans Working Group, Congressional Black Caucus Veterans Briantrust, and National Medical Association. With one of the primary focuses of these annual conferences being to highlight the need for more cultural sensitivity in diagnosing PTSD in African American veterans, and to recognize the frequently occurring dual presentation with mental disorders and substance abuse. The Center for Drug Abuse Research at Howard University and the Department of Psychiatry, Howard University Hospital served as the coordinating bodies for the implementation of the conferences. The conferences convened experts such as Dr. H. Westley Clark, Dr. Bambade Shakoor-Abdullah, Dr. Ledro Justice, Dr. Beverly Coleman-Miller, and many others from various disciplines to address the issues surrounding terrorism, trauma, and PTSD in the African American community, and mechanisms for improving early intervention efforts to decrease the risk of PTSD. Further, these annual conferences addressed recurring themes crucial to understanding and adequately addressing the occurrence of PTSD due to combat exposure, increased community violence, domestic violence, child abuse, and the effects of the September 11th bombing and anthrax attacks on the Greater Metropolitan Washington community and beyond.

**Post Traumatic Stress Disorder: A Latino Perspective**

*Martinez, Mercedes, MD, Lawndale Mental Health Clinic*

Latino/Hispanic Americans number approximately 37 million in the USA. They are a heterogeneous population. Central American refugees have a 33–60% incidence of PTSD. There are only 4.3% physicians and less in other skilled health fields that are Hispanic. This poses a dilemma for the culturally competent treatment for Hispanic patients. Lack of bilingual staff at one agency lead to an incidence of secondary PTSD that developed in a child of a Hispanic patient, who was translating for her. One of the most prevalent etiologies for PTSD continues to be inner city violence. Homicide is one of the leading causes of death and dysfunction striking young Latinos, as well as African Americans. The incidence of Latino homicide rate is two and a half times the homicide rate for Caucasians. Ongoing racism, poverty, lack of access to care, acculturative stressors, and daily fears (by children of undocumented Latinos) of arrest and deportation of their parents and relatives

Saturday: 1:00 p.m.–2:15 p.m.

## Saturday, November 1

by the INS, and other factors continue the traumatization of Latino/Hispanic Americans.

### Grantwriting 101

**Workshop (train) Parlor A, 6th Floor**

*Koenen, Karestan, PhD, National Center for PTSD; Keane, Terry, PhD, National Center for PTSD; Street, Amy, PhD, National Center for PTSD; Valera, Eve, PhD, Harvard University School of Medicine; Breiling, Jim, PhD, National Institute of Mental Health*

This workshop is sponsored by the Research SIG and was organized at member's request. The workshop is oriented towards post-docs, junior faculty, and others with little or no grant writing experience interested in obtaining grant support for their research. The workshop will take participants step-by-step through the grant writing process beginning with how to develop a fundable research idea, identify the appropriate funding agency, interact with the funding agency, write the grant, and put together the final "package" to be submitted. A representative from the National Institute of Mental Health will be present to answer questions and provide informational materials to participants. The panel will include senior, experienced, and successful grantwriters as well as junior faculty who have been successful in obtaining initial funding for their research. Participants should attend the workshop armed with questions!

### Assisted Recovery from Trauma and Substances: A Treatment Approach

**Workshop (practice) Parlor H, 6th Floor**

*Triffleman, Elisa, MD, The Public Health Institute; Wong, Phillip, PsyD, The Public Health Institute*

PTSD and substance use disorders frequently co-occur, resulting in an on-going need for treatment addressing and sensitive to both disorders. Assisted Recovery from Trauma and Substances (ARTS) is an integrative therapy for the concurrent treatment of PTSD and substance abuse. This clinically-oriented workshop will focus on the treatment principles and approach offered by ARTS. ARTS was initially developed for use in a research framework and has been pilot tested in two US samples. These studies have indicated that subjects preferentially attend ARTS in comparison with manualized treatments for substance abuse alone. Other study results will be briefly presented. ARTS is a cognitive-behavioral individual therapy designed for outpatients, utilizing a two-phased approach. In the first, or substance-focused trauma-informed phase, patients receive psychoeducation and coping skills training for both PTSD and substance abuse. In the second or trauma-focused, substance-informed phase, patients receive PTSD-specific interventions (including prolonged and in vivo exposures) while continuing active monitoring of addiction-related behaviors and cognitions. Toxicology screening for substance use occurs throughout treatment. The workshop will include discussion of the typical session format and of session topics. Videotaped clips of therapy sessions will illustrate how ARTS is implemented and some common therapeutic dilemmas will be discussed.

### Developing a Curriculum on Trauma for Psychiatry Trainees

**Workshop (culture) PDR #5, 3rd Floor**

*Anzia, Joan, MD, University of Illinois at Chicago; Smajkic, Amer, MD, University of Illinois at Chicago; Flaherty, Joseph, MD, University of Illinois at Chicago; Griffith, James, MD, The George Washington University Medical Center*

Trauma is often explicitly social in origin and more often the responses to trauma are highly enveloped by social and cultural phenomena, including the responses of psychiatric professionals. Modern psychiatry's advances in neuroscience and psychological diagnosis and treatment have made valuable contributions, but have left less room for consideration of other dimensions. Training in modern psychiatry may also fail to adequately address the actual experiences,

emotions, and memories of resident trainees, who are not uncommonly directly or indirectly linked to trauma, through family, community, societal, ethnic or political experiences, both in the domestic and international contexts. Addressing these dimensions requires that resident educators are grounded in multidisciplinary concepts and approaches which directly engage the social, cultural, ethical aspects of trauma. Most importantly, residency educators need to be able to translate these intellectual propositions into learning experiences, where residents are encouraged to think "out of the box" regarding social, cultural and ethical dimensions, and to integrate these propositions into the development of professional competency and identity. This presentation will share examples of specific curricular initiatives, ranging from the traditional to the innovative. Audience members will be encouraged to share examples from their own training programs illustrating successes, obstacles, opportunities, and challenges.

### American Indian Trauma Responses in the Wake of 9/11 and Bioterrorism

**Workshop (culture) Parlor B, 6th Floor**

*Yellow Horse Brave Heart, Maria, PhD, The Takini Network & Research, University of Denver; Yellow Horse, Susan, MSW, LCSW, The Takini Network Inc., University of Denver; DeBruyn, Lemyra, PhD, The Takini Network Inc.*

The purpose of this workshop is to increase participants' understanding of American Indian historical trauma and its relationship to Indian responses to 9/11, bioterrorism, and war. Historical trauma is cumulative emotional wounding across generations, including one's own lifespan, emanating from massive group trauma (Brave Heart, 1998, 1999, 2000). The historical trauma response (HTR) is a constellation of features in reaction to intergenerational traumatic history, similar to the survivor's child complex found among Jewish Holocaust descendants and Japanese American internment camp descendants. HTR may include: depression, suicidal behaviors, poor affect tolerance, psychic numbing, hypervigilance, trauma fixation, somatic symptoms, survivor guilt, anger, victim identity, loyalty to ancestral suffering, and identification with the dead. The events of 9/11, bioterrorism, and war may be viewed as historical trauma triggers among American Indians: re-experiencing the trauma of being attacked on their traditional homelands and fear of smallpox infestation, reminiscent of deliberate trading of smallpox-infected blankets with tribes. This workshop will (1) describe American Indian historical trauma and HTR; (2) elucidate the impact of 9/11, bioterrorism threats, and war upon American Indians; (3) present qualitative data from Native search and rescue teams that went to Ground Zero; and (4) present effective HTR interventions with American Indians.

### Client-Centered Therapy for Children's Traumatic Grief

**Case Presentations (child) Parlor F, 6th Floor**

*Goodman, Robin, PhD, New York University School of Medicine; Brown, Elissa, PhD, New York University School of Medicine; Valerian, Alison, PhD, New York University School of Medicine*

Empirical literature on the construct and treatment of children's traumatic bereavement is only beginning to emerge. Studies indicate that clinicians typically use both client-centered and cognitive behavioral techniques when working with these families. The first randomized controlled trial of children's traumatic bereavement is underway with families of uniformed service personnel (firefighters, police, port authority, emergency medical services) who were killed during the World Trade Center attack on September 11th, 2001. Families are evaluated at pretreatment and randomly assigned to client-centered or cognitive behavioral therapy, both of which consist of 16 weekly sessions of individual child and parent therapy. Post-treatment and six-month follow-up evaluations are conducted following treatment. Children's mental health outcomes include traumatic grief, posttraumatic stress disorder, depression, and exter-

## Saturday, November 1

nalizing behavior problems. The proposed paper is a case presentation of client-centered treatment (CCT) of a bereaved adolescent girl. The case will be described according to the concepts of the traumagenic model, specifically betrayal, stigmatization, powerlessness, and behavioral dysregulation. The manifestations of these core concepts in the clinician-parent and clinician-child therapeutic relationship, and their relevance to the session themes will be described. The identification of trauma and grief related themes as well as developmentally specific tasks also will be highlighted.

### Cognitive Behavioral Treatment for Children's Traumatic Grief

*Brown, Elissa, PhD, New York University School of Medicine; Goodman, Robin, PhD, New York University School of Medicine; Pearlman, Michelle, PhD, New York University School of Medicine*

Empirical literature on the construct and treatment of children's traumatic bereavement is only beginning to emerge. Studies indicate that clinicians typically use both client-centered and cognitive behavioral techniques when working with these families. The first randomized controlled trial of children's traumatic bereavement is underway with families of uniformed service personnel (firefighters, police, port authority, emergency medical services) who were killed during the World Trade Center attack on September 11th, 2001. Families are evaluated at pretreatment and randomly assigned to client-centered or cognitive behavioral therapy, both of which consist of 16 weekly sessions of individual child and parent therapy. Post-treatment and six-month follow-up evaluations are conducted following treatment. Children's mental health outcomes include traumatic grief, posttraumatic stress disorder, depression, and externalizing behavior problems. The proposed paper is a case presentation of the cognitive behavioral treatment (CBT) of a young boy whose father died. CBT is divided into two phases: (1) skill building, to address the traumatic nature of the death (affect regulation, relaxation, cognitive techniques, and gradual exposure), and (2) structured activities, to promote the bereavement process (by helping the family mourn the death). Each phase of CBT will be presented in the context of the evaluation findings and developmental considerations. Implications for the development of a comprehensive treatment model for traumatic grief will be discussed.

### 2:30 p.m.–3:45 p.m.

#### Family Systems and Culturally Sensitive Trauma Treatment

**Consultation (culture) Wabash Room, 3rd Floor**

*Hardy, Ken, PhD, Department of Family Studies, Syracuse University*

In many cases, the symptoms associated with mental illness stems from acute and often times chronic exposure to trauma. Therefore, to effectively treat mental illness, a paradigmatic shift is required that will allow providers to conceptualize and ultimately treat mental illness from a trauma sensitive perspective. A trauma sensitive approach is particularly critical when working with patients who are members of marginalized groups. For those who are poor, people of color, and/or female example, experiences with racism and sexism also can inflict trauma wounds. Moreover, because of the lack of strong ecological orientation with respect to understanding and treating mental illness, too many of our systems of care often inadvertently re-traumatize those who are already suffering from the wounds of familial and socioculturally-based trauma.

This workshop will outline the parameters of a multicultural, systemic approach to trauma sensitive mental health diagnosis and treatment. Special attention also will be devoted to examining how issues of class, race, and gender shape the provision of mental health care. Special emphasis will be placed upon discussing culturally competent ways of relating to patients, especially those who are marginalized on the basis of class, race, and/or gender.

#### International Trauma Training of Primary Care Providers

**Panel (disaster) State Ballroom, 4th Floor**

*Eisenman, David, MD, MSHS, Rand Corporation and University of California at Los Angeles School of Medicine; Agani, Ferid, MD, Kosovo Federal Ministry of Health; Rolland, John, MD, University of Chicago, Department of Psychiatry; Danieli, Yael, PhD, Group Project for Holocaust Survivors and Their Children*

This presentation of the Task Force on International Trauma Training addresses current activities and concerns of this ISTSS/RAND collaborative initiative. International trauma training is increasingly focused on training primary care providers (PCPs) to care for the mental health consequences and ongoing threat of mass violence. Despite practical and conceptual overlaps between primary care and mental health, it is still necessary to determine what such training is trying to achieve. David Eisenman will present the ISTSS/RAND Guidelines for International Trauma Training of Primary Care Providers. Innovative topics for the next millennium, including the nexus of mass trauma and HIV risk behavior, have pushed these guidelines into new territories. Second, Ferid Agani, Kosovo's Deputy Minister of Health, will apply the guidelines to frame his analysis of Kosovo's experiences with trauma training of PCPs. Third, John Rolland will present a collaborative and resilience-based, family systems approach to PCP trauma training that highlights the relationship of the guidelines to pioneering mental health interventions. The discussant, Task Force co-chair Yael Danieli, will discuss future directions that ISTSS and the guidelines can take in the changing global environment. Ample time will be available for dialogue on these and other possible Task Force activities.

#### Integrating Treatments in the Wake of Trauma: When, Who and How?

**Panel (clin res) Crystal Room, 3rd Floor**

*Monson, Candice, PhD, VA National Center for PTSD and Dartmouth Medical School; Friedman, Matthew, MD, PhD, VA National Center for PTSD and Dartmouth Medical School; Watts, Bradley, MD, White River Junction VARO & MC and Dartmouth Medical School; Rothbaum, Barbara, PhD, Emory University School of Medicine; Price, Jennifer, PhD, National Center for PTSD and Dartmouth Medical School*

Several psychosocial and psychopharmacological therapies have been established as powerful interventions for posttraumatic reactions. Medications and psychotherapy are often used simultaneously in clinical practice, in spite of relatively little empirical research about how these interventions should be integrated or timed to best ameliorate trauma sequelae. Meanwhile, there are limitations to existing empirically supported treatments, including problems in delivery (e.g., high attrition rates) and variable outcomes (i.e., 25% to 60% have diagnosable conditions post-treatment and at follow-up). The panel will discuss data on innovative biological (e.g., atypical antipsychotics, ECT) and psychosocial (i.e., Brief Integrative Therapy, Cognitive-behavioral Couple's Therapy for PTSD) therapies, and the integration of interventions (e.g., antidepressants and exposure therapy, adjunctive group therapy to facilitate individual exposure treatment). Particular attention will be paid to targeting micro- to macro-levels of functioning. Panelists and attendees will be invited to consider questions such as: How soon in the wake of trauma should intervention occur? Who should intervene with what? Is there an algorithm for the optimal sequence or combination of interventions? When does more intervention lead to fragmentation? Do medication and symptom-focused psychosocial treatments reduce the anxiety desired for some treatments and facilitate others? What are the short- and long-term considerations, including costliness?

**Saturday, November 1**

**State of the Art: Research in Dissociative Identity Disorder (DID)**

**Symposium (frag) Red Lacquer Room, 4th Floor**

**Featured Symposium**

*Chefetz, Richard, MD, Institute of Contemporary Psychotherapy & Psychoanalysis*

Drs. Boon, Draijer, Huntjens, and Dell will present their latest data on differentiation of imitated vs. genuine DID, inter-alter amnesia, and new diagnostic tools for DID, respectively. Dr. Chefetz will summarize their contributions and describe their clinical applicability.

**Research on Inter-Identity Amnesia in Dissociative Identity Disorder**

*Huntjens, Rafaele, PhD, Department of Clinical Psychology, Utrecht University; Postma, A., Department of Psychonomics, Utrecht University; Peters, M., Department of Clinical, Medical, and Experimental Psychology, Maastricht University; Woertman, L., Department of Psychology, Utrecht University; van der Hart, Onno, PhD, Department of Clinical Psychology, Utrecht University*

DID patients very frequently report episodes of inter-identity amnesia, in which an identity claims amnesia for events experienced by other identities. Whereas most clinical DID experts agree that DID is accompanied by a disturbance in episodic memory, they seem to disagree as to whether identities share implicit memory, such as priming and procedural memory, i.e., the expression of information without conscious recollection. We designed a series of cognitive studies to objectively determine the degree of information-transfer from one identity to another. Both explicit and implicit memory tests were used and both neutral and trauma-related material was included. Contrasting with previous studies, large patient samples were included (n >= 22) and special attention was given to exclude, or control for, the possibility of simulation of amnesia symptoms. The results of these critical studies all collude in that they showed evidence of transfer of information between identities. We therefore suggest that instead of an actual, objective inability to recall information, the patients' conviction of the inability to recall information seems central. Patients seem to lack the acknowledgment of remembered memories of other identities as belonging to themselves, which seems a direct result of their lack of an integrated feeling of identity.

**Reconceptualizing DID: An Expanded Domain of Dissociative Experience**

*Dell, Paul, PhD, Trauma Recovery Center, Psychotherapy Resources of Norfolk*

A subjective/phenomenological concept of dissociation has generated (1) a new understanding of the domain of dissociative experience, (2) a reconceptualization of dissociative identity disorder (DID), (3) new diagnostic criteria for DID, (4) a new MMPI-like measure of dissociation with five validity scales (Multidimensional Inventory of Dissociation; MID), and (5) new data that robustly support (a) the validity of the MID, (b) the reconceptualization of DID and (c) the proposed diagnostic criteria for DID. The proposed diagnostic criteria for DID consist of 23 dissociative symptoms that are organized into three symptom-clusters; (1) general dissociative symptoms, (2) symptoms that are partially dissociated from consciousness, and (3) symptoms that are fully dissociated from consciousness. The 23 dissociative symptoms have a Cronbach alpha coefficient of .98. A sample of 220 persons with DID were found to have a mean of 20.2 of the 23 symptoms. When compared to patients with borderline personality disorder (BPD), patients with DID had significantly higher dissociation scores. DID and BPD patients had similar levels of neurotic suffering (i.e., high) and endorsed similar numbers of rare symptoms (i.e., few). BPD patients, however, exhibited significantly more attention-seeking, factitious behavior, and manipulativeness than did DID patients.

**The Differentiation of Imitated DID from Genuine DID**

*Boon, Suzette, PhD, Altrecht Regional Psychiatric Center (RPC); Draijer, N., PhD, Department of Psychiatry, Vrije University Amsterdam*

Since the late eighties we have conducted systematic research on the diagnosis and differential diagnosis of dissociative disorders, in particular Dissociative Identity Disorder (DID) (Boon & Draijer, 1991, 1993a, b & c). Gradually we were confronted with cases of imitated DID. Using the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) for systematic assessment we compared cases of imitated DID with Genuine DID. We use the term "imitated DID" for patients who, partly unconsciously motivated, simulate a DID profile. We will present data on the clinical phenomenology of 36 patients with imitated DID and compare these with the data from our original study of 71 patients with genuine DID (Boon & Draijer, 1993 a & b). All patients with imitated DID met criteria for a personality disorder in particular borderline personality and histrionic personality disorder. In 55% of the cases of imitated DID the diagnosis was at one time confirmed by a clinician. The core dynamics behind DID symptom production in imitations of DID are 1) the avoidance of responsibility or feelings like shame for negative behaviors 2) the compensation for an overwhelming feeling of "not being seen, not being heard, not being recognized" and the "lack of identity". 3) getting more attention from clinicians and people from their support system.

**Improving Treatment of Posttraumatic Stress Disorder**

**Symposium (clin res) Monroe Ballroom, 6th Floor**

*Bryant, Richard, PhD, University of New South Wales; Keane, Terence, PhD, National Center for PTSD*

Psychological treatments of posttraumatic stress disorder (PTSD) are now attempting to increase treatment effectiveness through various approaches. Although cognitive behavior therapy (CBT) has been repeatedly shown to be effective in reducing PTSD symptoms across a wide range of populations, there is a need to develop approaches that increase the effectiveness of CBT for more trauma survivors. This symposium presents four treatment studies that focus on different attempts at increasing treatment effectiveness for PTSD. These attempts each address issues that potentially impede optimal treatment response in people affected by PTSD. These studies represent the most recent wave of treatment outcome research in the fields of PTSD. These approaches are building on proven approaches to extend their applicability to more people. Each of these studies adhered to gold standards of treatment outcome research. Overall, these studies provide innovative protocols in the treatment of PTSD and will be discussed in the context of the conference's theme of increasing treatment effectiveness.

**Imaginal Exposure Vs. In-Vivo Exposure in Treating PTSD**

*Bryant, Richard, PhD, University of New South Wales*

Exposure has been a highly efficacious intervention for posttraumatic stress disorder for many years. Exposure usually takes the form of either imaginal exposure to trauma memories or in vivo exposure to feared situations. Although exposure has been studied repeatedly in the treatment of PTSD, there is currently no reliable evidence pertaining to the relative efficacy of different forms of exposure. This paper reports the results of an ongoing study that compares four treatments of PTSD: (a) imaginal exposure, (b) in vivo exposure, (c) combined imaginal and in vivo exposure, and (d) supportive counseling. Treatment comprised 8 weekly 90-minute sessions administered on an individual basis. Civilian trauma survivors were randomly allocated to one of the four treatment conditions. Data will be presented on 80 patients who completed treatment. Imaginal exposure involves repeated exposure to memories of the traumatic experience. In vivo exposure involves graded exposure to a hierarchy of feared situations. Supportive counseling involved education, general problem-solving, and support. Participants were assessed, in part, with the Clinician Administered PTSD Scale, Impact of Event

## Saturday, November 1

Scale, and Beck Depression Inventory. Blind assessments were conducted at pretreatment, posttreatment, and six months posttreatment. Objective treatment fidelity ratings were conducted. Initial intent-to-treat analyses indicate that participants in the supportive counseling and in vivo exposure conditions had small reductions in PTSD symptoms than participants in the imaginal exposure condition, who in turn had small reductions than participants in the combined imaginal and in vivo exposure condition. More recent analyses will be provided and discussed in the context of the optimum form of exposure that should be provided with PTSD individuals.

### Bringing a Manualized Treatment for PTSD to the Community

*Cloitre, Marylene, PhD, New York University School of Medicine; Levitt, Jill, PhD, New York University School of Medicine; Davis, Lori, PhD, New York University School of Medicine; Miranda, Regina, MA, New York University Department of Psychology*

PTSD treatments have been successful in very well specified trauma samples such as victims of rape or motor vehicle accidents. However, little is known about the success of such treatments in community settings. While there are clear advantages to randomized controlled trials, researchers need to move beyond the confines of efficacy studies to test the effectiveness of manualized treatments in the community. The current study examines the application of Skills Training in Affective and Interpersonal Regulation plus Modified Prolonged Exposure (STAIR-MPE) in a community sample of New Yorkers affected by the terrorist attacks of September 11, 2001. STAIR-MPE is a 16-session, sequential treatment designed to improve affective and interpersonal functioning and reduce PTSD symptoms in childhood abuse survivors with adulthood traumas of interpersonal violence. In early assessment of 9/11 survivors seeking treatment, it was found that the majority reported a previous trauma history, thus suggesting that STAIR-MPE could be an appropriate treatment for this sample. The effectiveness of STAIR-MPE will be compared to treatment as usual in the community. The presentation will focus on predictors of outcome, and differences between the two treatments on PTSD symptoms, depression, negative mood regulation capacity, social support and functional impairment at treatment end.

### CBT for PTSD for Partial Treatment Responders

*Foa, Edna, PhD, University of New South Wales; Hembree, Elizabeth, PhD, University of Pennsylvania; Rauch, Sheila, PhD, University of Pennsylvania; Cahill, Shawn, PhD, University of Pennsylvania*

There is now considerable evidence that relatively brief treatment with cognitive-behavior therapy (CBT) can significantly reduce symptoms in many people with posttraumatic stress disorder (PTSD). However, in most of these studies there remains a group of participants who receive only a partial benefit from treatment. For purposes of experimental control, efficacy studies typically limit treatment to a specific number of sessions that is determined in advance by the investigator, and is not related to the progress of any particular study patient. This predetermined limit on the number of sessions raises the question, "Do partial responders to a standard course of treatment benefit from additional sessions of the same treatment, or do they require shifting to an alternative treatment?" This lecture presents data from a recently completed efficacy study of prolonged exposure (PE) with and without cognitive restructuring that incorporated a flexible decision rule to determine when treatment would be terminated. For participants who obtained a 70% reduction in self-reported PTSD symptoms by Session 8, treatment was terminated at Session 9. Participants who did not attain a 70% reduction were offered 3 additional sessions (12 sessions total). At Session 8, participants who met the criteria for termination had significantly lower PTSD severity scores ( $M = 8.7$ ) than those who did not ( $M = 22.3$ ), although the groups had not differed at the pretreatment assessment ( $M_s = 32.0$  and  $32.1$ , respectively). The group of partial responders showed continued reduction in PTSD severity after receiving additional treatment. However, an analysis of posttreat-

ment scores revealed that early treatment responders had significantly lower levels of PTSD ( $M = 4.9$ ) and depression ( $M = 4.7$ ) than did participants who received three additional sessions ( $M_s = 11.6$  and  $9.1$ , respectively). These results suggest that individuals who show a partial response after a standard course of CBT may benefit from continued treatment.

### Treating PTSD with Cognitive Processing Therapy or Prolonged Exposure

*Resick, Patricia, PhD, University of Missouri, St. Louis; Galovski, Tara, PhD, University of Missouri, St. Louis*

Both cognitive processing therapy (CPT) and prolonged exposure (PE) have been demonstrated to be effective for the treatment of PTSD and trauma-related depression among survivors of rape. In a study comparing CPT, PE and a delayed treatment control, more than 80% of each active treatment group lost their PTSD diagnosis, and good end-state functioning was found in 76% of the CPT and 58% of the PE treatment completers. The waiting group did not change. Because PTSD has been viewed as a chronic and treatment-resistant disorder, it is important to determine if the results of these protocols, albeit successful in the short term, continue to have a lasting effect over time. The purpose of this presentation will be to report on an ongoing effort to conduct comprehensive follow-up assessments on everyone who participated in the clinical trial comparing CPT and PE (Resick et al., 2002). There were 171 participants in the intent-to-treat sample who are being contacted and assessed at five years or more posttreatment. At the point of submission, 61 have been assessed: 24 CPT and 26 PE completers, and 11 who dropped out of treatment. We will compare data on PTSD, depression, cognitions, further treatment, and revictimization among these groups.

### Recent Developments in Clinical Research on Complex PTSD II: Treatment

Symposium (clin res)

Grand Ballroom, 4th Floor

#### Featured Symposium

#### Endorsed by the Child Trauma Special Interest Group

**Participants are advised that the presentation will include self-disclosure of personal information exercises asking participants to focus on past upsetting events.**

*Spinazzola, F., PhD, The Trauma Center, Boston University School of Medicine; van der Kolk, Bessel A., MD, The Trauma Center, Boston University School of Medicine*

Children and adolescents exposed to chronic trauma routinely exhibit interrelated psychiatric and psychosocial difficulties beyond those targeted in treatments for PTSD. This symposium introduces three interventions designed to address these broader sequelae of childhood trauma in developmental context. Preliminary outcome findings are presented on trauma-related symptom reduction and impact on compromised domains of self-regulatory and psychosocial functioning.

### Group Treatment for Adolescents with Complex PTSD

*DeRosa, Ruth, PhD, North Shore University Hospital, Department of Psychiatry; Pelcovitz, David, PhD, North Shore University Hospital, Department of Psychiatry; Shannon, Maureen, MS, PhD, Nassau BOCES, TeenAge Parenting Program; Baker, Kristan, MS, North Shore University Hospital, Department of Psychiatry*

This presentation will describe a community-based, pilot group therapy program for adolescents with Complex PTSD symptomatology. This manualized approach is based on three empirically validated interventions that were adapted and integrated in an effort to address the topics specifically relevant to exposure to chronic interpersonal violence while also addressing developmental issues

**Saturday, November 1**

unique to adolescents. The broad treatment goals include 1) Managing the Moment: multiple sessions and practice assignments to help participants learn how to manage and to regulate their affect and impulses more effectively "here and now" when experiencing acute distress; 2) Building Coping Strategies: intended to help participants enhance their ability to cope with the impact of the trauma including psychoeducation, identifying emotions, thoughts and triggers, anger management, problem solving strategies; and 3) Enhancing Resiliency: designed to help participants identify current adaptations to the trauma that are working well and to enhance supports and buffers to the extreme stress. Clinical recommendations for work in community settings with at-risk adolescents will be explored. Preliminary findings from group work in residential treatment will be discussed.

**Treatment of Adolescent Girls with Childhood Abuse**

*Cloitre, Marylene, PhD, New York University Child Study Center*

Adolescent girls with childhood sexual and/or physical abuse show high rates of Posttraumatic Stress Disorder (PTSD) and have significant impairments in affect regulation and social competence. In addition, PTSD in adolescence is a powerful risk factor for the development of substance abuse problems, suicide attempts and revictimization. Thus, adolescence is a time of tremendous risk for multiple negative outcomes and there is urgent need for intervention during these years. We present a 16-week individual treatment program for adolescent inner-city girls organized into two sequential components: a 10-week module focused on Skills Training in Affective and Interpersonal functioning (STAIR) followed by a 6-week individual trauma-focused intervention that consists of narrative story telling (NST) about the traumatic experiences. The emphasis of the treatment, consistent with the developmental tasks of adolescence, is the organization of views about self that integrate trauma history with an emerging sense of self as competent and worthwhile. Throughout the treatment, therapist and client engage in partnership with community organizations to enhance skills in the "real world" and build success experiences. Preliminary data reveal improvements in PTSD symptoms, dissociation, depression, anger expression and social competence as compared to a supportive therapy and to skills training alone.

**An Integrative Treatment Model of Child/Adolescent Complex Trauma**

*Lantree, Cheryl, PhD, Miller Children's Hospital Abuse and Violence Intervention Center (MCAVIC)*

This paper will describe empirically-based, integrated, multi-modal treatment approaches provided by a hospital-based multidisciplinary outpatient center for economically-deprived children and adolescents traumatized by physical and sexual abuse, domestic and community violence, and/or loss of family member. Due to extensive poverty, parental substance abuse, parent-child attachment issues, and multiple traumatic events, the majority of clients experience complex PTSD. Comprehensive clinical evaluations including standardized measures such as the Trauma Symptom Checklist for Children assess for symptoms of complex trauma such as dissociation and affect regulation (i.e., anger) as well as post-traumatic stress. As a Community Treatment and Services Center of the SAMHSA-funded National Child Traumatic Stress Network, treatment interventions continue to be expanded and refined to provide an optimal standard of care in a culturally diverse, high need community. Results will be presented from outcome studies examining the effectiveness of empirically-based, trauma-specific treatment models conducted in clinic- and school-based contexts. Individual treatment approaches to be discussed are assessment-driven targeting trauma symptoms and include play and art therapy, cognitive-behavior therapy, and attachment-based interventions while also emphasizing developmental aspects of trauma-specific symptoms. Group and family treatment approaches will also be discussed, as will circumstances for more extensive treatment due to complex psychological trauma.

**Intimate Partner Violence: Threat Appraisal, Coping, and PTSD**

**Symposium (clin res) Parlor F, 6th Floor**

*Dutton, Mary Ann, PhD, Georgetown University Medical Center*

This panel will present empirical data from two studies involving female victims of intimate partner violence: one in the U.S. and the other in Japan. Individual papers will address threat appraisal, coping, and traumatic stress reactions among these women. The paper on threat appraisal will focus on factors that influence battered women's subjective perception or understanding of danger, as well as the level of predictive power of those appraisals for the realization of IPV-specific threats one year later. Two papers address coping. The first of these focuses on battered women's strategies for dealing with the effects or aftermath of intimate partner violence and the relationship between these strategies and posttraumatic symptoms. The second coping paper focuses on battered women's decision to remain in or leave an abusive relationship. Finally, a study of battered women in Japan examined effects of anger expression and parental behavior on PTSD of Japanese battered women. Treatment and policy implications for these findings will be addressed.

**The Effect of Relationship Dynamics on Battered Women's Experiences**

*Bell, Margret, MA, Boston College; Goodman, Lisa, PhD, Boston College; Dutton, Mary Ann, PhD, Georgetown University*

Many interventions with battered women rest on the assumption that women must end their relationships in order to improve their psychosocial functioning and decrease their experiences of violence. Advocates have begun to question this assumption, however, drawing from the well known finding that violence can increase when women leave their partners and anecdotal evidence that many battered women don't want to leave their partners. We set out to address this issue by comparing outcomes for women with different relationship trajectories, using a longitudinal sample of 400 low-income, primarily African American victims of IPV. Preliminary results indicate that women who stayed apart from their abusers over the course of the entire year reported a significantly higher quality of life ( $p = .01$ ) and lower levels of physical abuse ( $p = .03$ ), psychological abuse ( $p = .00$ ) and stalking ( $p = .04$ ) one year later (after controlling for initial levels of these variables) relative to women who stayed involved in the relationship even for part of that year. While these data support the notion that overall, women who separate from their partners are more likely to become violence-free and emotionally secure over time, they leave open the important question of how subgroups of women who follow different relationship pathways may fare.

**Emotion-Focused Coping in Battered Women: Correlates and Outcomes**

*Kaltman, Stacey, PhD, Georgetown University Medical Center; Dutton, Mary Ann, PhD, Georgetown University Medical Center; Goodman, Lisa, PhD, Boston College*

The prevalence of intimate partner violence and its negative mental health consequences are both astonishingly high and well-documented. However, very little is known about how battered women cope with the violence they experience and how coping efforts are related to mental health outcomes. The current study seeks to examine prospectively the emotion-focused coping strategies employed by battered women as well as the correlates and outcomes of emotion-focused coping use. The data presented are derived from a larger longitudinal study of a low-income, primarily African American community sample of battered women. The development and psychometrics of a new battered women's emotion-focused coping scale will be discussed. Overall, the sample employed many and varied emotion-focused coping strategies. At baseline, emotion-focused coping was negatively associated with depressive symptomatology ( $p < .01$ ), level of violence ( $p < .05$ ) and

**Saturday, November 1**

level of psychological abuse ( $p < .01$ ). Emotion-focused coping was positively associated with quality of life ( $p < .001$ ). Emotion-focused coping use at baseline was predictive of higher quality of life ( $p < .001$ ) and less cumulative violence ( $p < .01$ ) four months later. Findings regarding the correlates and outcomes of subtypes of emotion-focused coping will be presented and the clinical implications of these findings will be discussed.

**Determinants of Battered Women's Threat Appraisal**

*Dutton, Mary Ann, PhD, Georgetown University Medical Center; Goodman, Lisa, PhD, Boston College; Weinfurt, Kevin, PhD, Duke University; Vankos, Natalie, MS, Georgetown University Medical Center; Kaltman, Stacey, PhD, Georgetown University Medical Center*

Many victims of intimate partner violence (IPV) live with the ongoing threat of violence and abuse from their intimate partners. Indeed, women typically experience IPV repeatedly in their intimate relationship. In addition to the risk of revictimization, living with the continued expectation of future IPV can both constrain personal freedoms, as well as exact an emotional toll on victims. Indeed, a recent study of coping among women found that threat appraisal was a central component of stress (Hudek-Knezevic & Kardum, 2000). However, we know little about battered women's threat appraisal. The purpose of this paper was to examine potential factors associated with IPV threat appraisal among a sample of predominately low income, urban, African-American battered women. Univariate logistic regression analyses found that all violence variables (physical, sexual, stalking, psychological) and 10 other IPV risk factors significantly predicted total IPV threat appraisal at  $p < .001$ . Multivariate logistic regression revealed that stalking (OR = 10.7), psychological abuse (OR = 3.6), IPV during pregnancy (OR = 2.7), threat to kill (OR = 2.1), abuser's suicidality (OR = 1.9), and abuser's access to a gun (OR = 1.9) contributed uniquely to the prediction of women's own IPV threat appraisal. Further, women's IPV threat appraisal predicted actual IPV outcomes one year later. Implications for practice will be discussed.

**Risk Factors of PTSD on Battered Women: Anger Expression/Parental Behavior**

*Ishii, Tomoko, PhD, Tokyo Institute of Psychiatry, Setagaya-ku, Tokyo; Asukai, Nozomu, MD, PhD, Tokyo Institute of Psychiatry; Kimura, Yumiko, Musashino Women's University; Nagasue, Takako, MA, Musashino Women's University; Kurosaki, Michiko, MA, Shizu Clinic*

We already reported that among battered women from a shelter in Japan ( $n=60$ ) interviewed 40.0% ( $n=24$ ) met DSM-IV criteria for PTSD by CAPS. The PTSD group was more variously and repeatedly victimized than those Non-PTSD group. The Anger-In which is the individual's typical tendency to suppress angry feelings is positively related to depression and PTSD (Tivis, L.J., et.al 1998). Over-Protection by the mother was significantly associated with depression (Parker G et. al, 1995). The purpose of the current study is to investigate the effects of anger expression trait and parental behavior on PTSD of battered women in Japan. Battered women from the shelter in Japan ( $n=55$ ); PTSD group ( $n=18$ ) and Non-PTSD group ( $n=37$ ) were participants in the study. Measures include the State Trait Anger Expression Inventory (STAXI) and the Parental Bonding Instrument (PBI). The PTSD group's scores on Anger-In subscale of the STAXI ( $F= 3.67$ ,  $df = 27.6$ ,  $p < .0001$ ) and Over-Protection Factor of Mother ( $F= 2.5$ ,  $df = 29.9$ ,  $p < .05$ ) subscale on the PBI were higher than for the Non-PTSD group. On the other hand, There were no significant differences in the Anger-Out and Anger-Control subscales of the STAXI and Care Factor and Over-Protection Factor of father and Care Factor of mother subscales of the PBI between the PTSD group and Non-PTSD group. Implications for treatments with battered women in Japan will be discussed.

**Clinical Practice, Human Rights, and Impunity: Challenging Crossroads**

**Symposium (culture) Parlor H, 6th Floor**

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

*Fabri, Mary, PsyD, The Marjorie Kovler Center for the Treatment of Survivors of Torture*

Who should be held responsible for crimes against humanity? Efforts to secure justice for human rights violations are being implemented internationally. Following an overview of laws and mechanism for prosecuting torturers, information collected through interviews with plaintiffs and clinicians who have participated in anti-impunity lawsuits will be presented.

**The Pursuit of Justice Through Anti-Impunity Work**

*Portman, Scott, BFA, Heartland Alliance for Human Needs and Human Rights*

Most survivors of torture are advocates for justice rather than retribution, and many consider the pursuit of justice a key factor in recovering their autonomy and dignity. Justice, as opposed to retribution, implies an impartial judicial process in which perpetrators are confronted with the consequences of their crimes, creating an accurate and public historical record. Over the last decade, there has been a dramatic expansion in international courts to obtain justice for torture survivors, such as the UN War Crimes Tribunals for Rwanda and the former Yugoslavia. The United Nations has recently established the International Criminal Court (ICC). Despite the United States failure to ratify the treaty for the ICC, civil and criminal laws provide an opportunity for torture survivors to initiate legal action against perpetrators entering the United States. This presentation will focus on the use of the courts, both local and international, to establish a record of human rights abuses, assess responsibility, and provide an opportunity for survivors' voices to be heard. A historical overview of laws and mechanisms for prosecuting torturers, current efforts to bring torturers to justice, and the future of universal jurisdiction for torture and other crimes against humanity will be discussed.

**Anti-Impunity Work with Torture Survivors: The Clinician's Perspective**

*Gupta, Sonali, PsyD, International Institute of Boston; Fabri, Mary, PsyD, The Marjorie Kovler Centre for the Treatment of Survivors of Torture; Portman, Scott, The Marjorie Kovler Center for the Treatment of Survivors of Torture*

Anti-impunity work may be a significant component of the clinician's therapeutic work with survivors of torture. This presentation explores the intersections and boundaries between various aspects of the therapeutic and anti-impunity work from the perspective of the clinician. A series of semi-structured interviews were conducted with five clinicians who provide psychotherapy services to survivors of torture and also engage in anti-impunity work. Clinicians described socio-political factors and personal motivations or ideologies as leading to and perpetuating their involvement in the torture treatment field and in the anti-impunity movement. They discussed their conceptualization of their role in the context of the psychotherapy and the anti-impunity work and stressed the importance of maintaining a clear sense of one's role in order to implement appropriate interventions. They described the therapeutic framework within which the anti-impunity work is carried out and the positive and negative effects of the this work on the therapeutic process and client-clinician relationship are considered. Finally, the interviewees also related the significant ways in which working with survivors of torture and engaging in anti-impunity work has influenced and impacted them in both their professional (e.g., counter-transference) and personal (e.g., worldview, political beliefs) realms.

Saturday: 2:30 p.m. - 3:45 p.m.

**Torture Survivors Creating Meaning Through Anti-Impunity Efforts**

*Fabri, Mary, PsyD, The Marjorie Kovler Center for the Treatment of Survivors of Torture*

One aspect of psychological rehabilitation after a severe trauma, such as torture, is creating meaning for one's life after the event. Impunity often goes hand in hand with human rights abuses, and may deter psychological healing. How do anti-impunity efforts affect psychological outlook and symptoms? Structured interviews were conducted with four torture survivors who were plaintiffs in two successful anti-impunity cases in United States courts. The interviews included background information, personal motivation for filing, reflections on the legal process, and a self-assessment of psychological symptoms before and after their cases were heard. Two Bosnians and two Salvadorans were interviewed. Each reported different motivations for engaging in the cases. All four agreed that the opportunity to confront their perpetrators was a factor in making the decision to participate in the lawsuit. All four expressed an increase in fear after making the decision to participate. The number of psychological symptoms remained constant throughout the process, with all experiencing symptoms consistent with a diagnosis of Post Traumatic Stress Disorder. Although psychological symptoms were not alleviated, each survivor reported finding meaning or purpose from their experiences of exposing human rights violations in their country of origin, testifying in a judicial setting, and confronting their perpetrators.

**Examining the Complex Puzzle of PTSD and Substance Abuse**

**Symposium (clin res) Parlor A, 6th Floor**

*Riggs, David, PhD, University of Pennsylvania; Foa, Edna, PhD, University of Pennsylvania*

These papers examine links among trauma, PTSD and substance abuse. One documents trauma/PTSD among persons treated for cocaine abuse; the second examines changes in PTSD during early abstinence; the third outlines steps to prevent substance abuse after trauma; the fourth evaluates a treatment program for comorbid PTSD and alcohol dependence.

**Reductions in Trauma Symptoms During Alcohol and Cocaine Abstinence**

*Coffey, Scott, PhD, University at Buffalo, State University of New York; Schumacher, Julie, PhD, University at Buffalo, State University of New York; Brady, Kathleen, MD, PhD, Medical University of South Carolina; Dansky, Bonnie, PhD, CB Technologies Inc.*

Previous research with substance users has demonstrated, across a variety of psychiatric disorders, significant decreases in psychological symptoms during early substance abstinence (e.g., Brown & Schuckit, 1988). Whether PTSD symptomatology adheres to this demonstrated pattern or whether PTSD symptoms increase during early substance abstinence has not been studied prospectively. Due to the high co-occurrence of trauma and PTSD in substance abusing populations, this important diagnostic issue may have serious treatment implications. This presentation will describe a study that prospectively assessed trauma symptoms over 28 days during early substance abstinence. Participants were 162 cocaine and/or alcohol dependent outpatients who reported a history of trauma that satisfied criterion A for PTSD (28% met criteria for current PTSD). Trauma-related symptoms, withdrawal symptoms, and substance use were assessed at 2, 5, 10, 14, 21, and 28 days following last substance use. Hierarchical linear modeling was employed to estimate changes in trauma and withdrawal symptomatology. PTSD symptoms and abstinence symptoms significantly declined across the study period regardless of withdrawal substance. Moreover, trauma and withdrawal symptoms declined irrespective of PTSD status. Since the findings from this study may be inconsistent with clinical assumptions of traumatized substance users, important diagnostic and treatment planning issues will be discussed.

**An Acute Phase Intervention to Prevent Post-Rape Substance Use/Abuse**

*Acierno, Ron, PhD, Medical University of South Carolina; Resnick, Heidi, PhD, Medical University of South Carolina; Flood A., PhD, Medical University of South Carolina; Lebouef, F., PhD, Medical University of South Carolina; Kilpatrick, Dean, PhD, Medical University of South Carolina*

Many rape victims experience extremely high levels of distress immediately post-rape, and are also at increased risk of long-term psychopathology and substance use or abuse. The degree of initial acute distress appears to predict future negative affect, and substance use may represent efforts to ameliorate this distress. Unfortunately, the nature of post-rape forensic evidence collection procedures may exacerbate initial anxiety, thereby potentiating post-rape negative emotional effects. To address this, a two-part video intervention was developed for use in acute post-rape time frames to: (a) minimize anxiety during forensic rape exams, and (b) prevent increased post-rape substance use and abuse. Pilot study data with 124 rape victims indicated that the low cost, easily administered intervention was effective in reducing risk of marijuana abuse at 6 weeks post-rape (5.1% of viewers vs. 16.1% of non-viewers). Non-statistically significant trends also were evident for reduced marijuana use. Trends were also evident in favor of the video intervention in the sub-group of women who were actively using substances pre-rape (among pre-rape alcohol users, 28% video viewers vs. 43% non-viewers met criteria for post rape alcohol abuse; among pre-rape marijuana users, the rates of post-rape marijuana abuse were 17% vs. 43%). A large-scale dismantling study is currently underway to determine which aspects of the intervention (e.g., exam distress minimization; psychoeducation to prevent symptom development) are associated with treatment gains.

**Physical & Sexual Abuse, PTSD and Psychiatric Symptoms in Cocaine Dependent Women**

*Cook, Joan, PhD, University of Pennsylvania and Philadelphia VA Medical Center; Cacciola, John, PhD, University of Pennsylvania and Philadelphia VA Medical Center; Alterman, Arthur, PhD, University of Pennsylvania and Philadelphia VA Medical Center; Rutherford, Megan, PhD, University of Washington*

This study examined the relationship between physical and sexual abuse, substance use, PTSD, and psychiatric comorbidity in a treatment seeking sample of cocaine dependent women (N = 137). 24.8% of women reported lifetime physical abuse, 17.5% reported sexual abuse and 33.6% reported physical and sexual abuse. Structured clinical interviews revealed that 13% percent of the sample met DSM-criteria for current PTSD. Comparisons between individuals with and without current PTSD revealed that individuals with PTSD had significantly higher rates of psychiatric symptomatology including depression. Possible psychiatric sequelae accompanying trauma including PTSD have highlighted the need for identification and treatment of trauma survivors among those seeking drug abuse treatment.

**Treating PTSD and Alcohol Dependence Concurrently: Preliminary Findings**

*Riggs, David, PhD, University of Pennsylvania; Foa, Edna, PhD, University of Pennsylvania; Volpicelli, Joseph, MD, PhD, University of Pennsylvania; Rukstalis, Margaret, MD, University of Pennsylvania; Imms, Patricia, RN, University of Pennsylvania; Kalmanson, Danielle, BA, University of Pennsylvania; White, Lenea, MD, University of Pennsylvania*

Posttraumatic stress disorder (PTSD) and substance use disorders (SUD) commonly occur comorbidly. Theory and data suggest a very complex relationship among the factors of trauma exposure, post-traumatic symptoms, and substance use/abuse that raises potential pitfalls for the treatment of PTSD and/or SUD. Treatments that target the SUD may result in increased PTSD symptoms leading patients to drop out of treatment. Conversely, treatments that target PTSD

**Saturday, November 1**

symptoms may increase cravings for and use of substances. The present paper presents preliminary outcome data from a study that utilizes concurrent treatment with prolonged exposure, aimed at treating PTSD, and Naltrexone with supportive counseling, aimed at reducing alcohol dependence. Data from the first 50 participants in the treatment program indicate that the treatments are effective in reducing both PTSD symptom severity and alcohol consumption as long as the participants are able to complete at least 12 sessions. Additional results suggest that the drop-out rate from this program is comparable to that found in previous studies of the two independent treatments despite high rates of risk factors for drop-out (e.g., unemployment, homelessness). Discussion will focus on the promise of this concurrent treatment program and the adjustments necessary to discourage drop-out.

**Posttrauma Emotional Functioning: Alexithymia and Emotional Numbing**

**Symposium (clin res) PDR #5, 3rd Floor**

*Vernon, Laura, PhD, Auburn University; Roemer, Elizabeth, PhD, University of Massachusetts at Boston*

It is increasingly recognized that psychopathology is associated with disturbed emotional processing and functioning. Recent research and theory highlight the importance of considering emotional numbing and alexithymia in response to trauma. The purpose of this symposium is to highlight original research examining different aspects of emotional functioning following trauma.

**Relations Among PTSD, Alexithymia, Attributions and Trauma Characteristics**

*Vernon, Laura, PhD, Auburn University; Berenbaum, Howard, PhD, University of Illinois at Urbana-Champaign*

Recent research has documented disturbed emotional functioning following trauma. Elevated levels of alexithymia, a diminished ability to identify and describe one's emotions, has been reported in rape victims and holocaust survivors. The goal of the present study was to extend current research to examine associations among alexithymia, causal attributions, trauma characteristics, and current PTSD symptom level following a broad range of traumas experiences (e.g., motor vehicle accidents, physical assault, sexual assault). Undergraduate students who reported exposure to trauma (N = 150) during a verbal administration of the Life Events Questionnaire from the Clinician-Administered PTSD Scale completed the PTSD checklist, the Toronto Alexithymia Scale, and a measure to assess trauma characteristics (e.g., harm, loss) and attributions (e.g., internal, external). A multiple regression analysis was conducted with PTSD symptom level entered as the dependent variable and alexithymia, three attribution variables, and four trauma characteristic variables entered as the independent variables. PTSD symptom severity was positively predicted by alexithymia, psychological loss, and a feeling of contamination. Implications for future research and clinical applications for trauma survivors will be discussed.

**Emotional Processing in Sexually Assaulted Women**

*Palmieri, Patrick, PhD, University of Illinois at Urbana-Champaign; Berenbaum, Howard, PhD, University of Illinois at Urbana-Champaign*

Trauma researchers have utilized the emotional Stroop task to investigate attentional biases toward trauma-relevant information. Generally, such research focuses on diagnostic groups (PTSD, No PTSD), examines how color-naming response times to trauma-relevant words differ from those to other types of words (neutral, positive, general threat), and utilizes blocked stimulus presentation. However, it is also potentially valuable to examine emotional processing regardless of diagnostic status, not focus primarily on the processing of trauma-relevant stimuli, and use randomized stimulus

presentation. The present study utilized a computerized emotional Stroop task to examine emotional processing in a sample of sexually assaulted college students (n=31) and control subjects (n=35). Neutral, positive, general threat, and trauma-relevant words were presented in randomized format and response latencies were recorded. Then participants completed the PCL and several emotion measures. A repeated measures ANOVA revealed a significant group by word-type interaction on Stroop response times. Among assaulted women, interference scores for positive words correlated negatively with the PCL Emotional Numbing subscale. Several composite scores were also created to examine different aspects of emotional numbing, and these showed distinct correlational patterns with the PCL subscales. Results will be discussed in terms of clinical implications and possible future research.

**Alexithymia in Battered Women: Increasing Our Understanding**

*Valera, Eve, PhD, Massachusetts General Hospital Department of Psychiatry/Harvard Medical School; Berenbaum, Howard, PhD, University of Illinois at Urbana-Champaign*

Alexithymia is a personality characteristic whose features include the diminished abilities to identify and verbally communicate one's own emotions. Elevated levels of alexithymia have been linked to trauma as well as mental health problems such as depression and posttraumatic stress disorder. Further, research suggests that assessing alexithymia may be valuable for understanding and treating psychological disturbances. Surprisingly however, there appears to be no research examining levels of alexithymia in battered women, or how alexithymia relates to battered women's trauma (e.g., partner abuse) or emotional functioning. Thus, in this study we assessed ninety-nine battered women using the Toronto Alexithymia Scale-20 and a battery of psychopathological and abuse history measures. Women were recruited from both shelters and community-based programs. Correlational analyses revealed that elevated levels of alexithymia were related to partner abuse severity over the past year. Further, alexithymia was also highly associated with general distress, worry, anxious arousal, anhedonic depression, and PTSD symptomatology. The relationship between alexithymia and partner abuse severity was significant independent of its relationship to these measures of psychopathology. These findings stress the need for more research examining alexithymia in battered women as well as the role alexithymia may play in the efficacy of intervention techniques.

**Dissociative Symptoms and Auditory Hallucinations in Torture Survivors**

**Symposium (frag) PDR #4, 3rd Floor**

*Okawa, Judy, PhD, Center for Multicultural Human Services*

This symposium describes the phenomenology of dissociative symptoms among torture survivors, utilizing the Trauma Symptom Inventory and clinical psychiatric interviews. Dissociative auditory hallucinations are distinguished from those of psychotic disorders, with which they are often confused. Clinical implications of these findings are discussed for the psychotherapy and pharmacotherapy of PTSD.

**Psychiatric Treatment for Auditory Hallucinations in PTSD**

*Griffith, James, MD, Department of Psychiatry & Behavioral Sciences, George Washington University Medical Center*

Psychiatric treatment for psychotic symptoms in PTSD has received little systematic study. Auditory hallucinations previously have been reported in 30% to 40% of combat-related PTSD, and PTSD in 45% to 55% of patients with schizophrenia. Distinguishing dissociative (post-traumatic) from schizophreniform hallucinations is important, since optimal therapies differ for each, and an incorrect attribution of psychosis can risk demoralizing a traumatized person. Based on a literature review and our current data, we propose as criteria for distinguishing dissociative from schizophreniform hallucinations:

Saturday: 2:30 p.m. - 3:45 p.m.

Saturday, November 1

Auditory hallucinations are more likely dissociative when maximal during nightmares or flashbacks: specific voices are recognized as actual memories; voices express trauma-related content; or, rarely, voices are felt as comforting presences of real people. Hallucinations are more likely psychotic when associated with cognitive impairments, delusions, or negative symptoms (apathy, amotivation, social withdrawal); or voices are multiple in number, speak continuously, or comment upon mundane details of daily life. First-generation antipsychotic medications have been reported to be ineffective for dissociative hallucinations. Our data suggest that dissociative hallucinations often remit alongside other post-traumatic symptoms with multi-modality trauma treatment. Second-generation, atypical antipsychotic medications have been consistently effective, often in low doses. Illustrative cases are presented.

**Auditory Hallucinations Among Torture Survivors with PTSD**

*Gaby, Lynne, MD, Department of Psychiatry, George Washington University Medical Center; Griffith, James, MD, Department of Psychiatry, George Washington University Medical Center*

Psychotic symptoms, particularly auditory hallucinations, have been reported among PTSD patients, but there has been no clear consensus regarding their diagnostic and treatment implications. This lack of clarity is significant for torture survivors with post-traumatic hallucinations. Misdiagnosis of a psychotic disorder risks both unnecessary treatment and a psychiatric labeling that can diminish the political and moral meaning of the person's suffering. A retrospective review of 108 new referrals to a political torture-survivor treatment program revealed that 28 (26%) reported auditory hallucinations during a routine diagnostic psychiatric evaluation. These hallucinations were not accompanied by other signs of psychosis, such as delusions or affective blunting. These voices most often reflected trauma-related content, but often occurred separate in time from re-experiencing symptoms, such as flashbacks and nightmares. 18 of 28 required no antipsychotic medication, with hallucinations resolving quickly with the initiation of a multi-modality treatment model. 10 others were treated with low-dose atypical antipsychotic medications with rapid improvement (olanzapine 5 mg daily, quetiapine 100 mg daily, risperidone 1 mg daily, or less). These findings suggest that auditory hallucinations in torture survivors do not typically reflect a co-morbid psychotic disorder and do not require antipsychotic medications as typically prescribed for Axis I psychoses, such as schizophrenia.

**Hallucinations and Other Dissociative Symptoms in Torture Survivors**

*Okawa, Judy, PhD, Center for Multicultural Human Services*

Torture survivors receiving treatment at CMHS's Program for Survivors of Torture and Severe Trauma in Falls Church, VA, present with a myriad of symptoms that go beyond the DSM-IV constructs of post-traumatic stress disorder and dissociation. Victims report experiencing extensive dissociative symptoms, including depersonalization (including out-of-body experiences), derealization, amnesia, emotional numbing, dissociative flashbacks, auditory hallucinations, somatoform symptoms (including paralysis and disconnection from one's own body or body parts), absorption, and identity disturbance. This presentation will report the results of a review of archival records of Trauma Symptom Inventory protocols of 60 torture survivors with a focus on auditory hallucinations and dissociative symptoms. The Atypical Response validity scale was elevated in 24 (40%) out of 60 records. In 36 records with non-elevated ATR scales, 9 (25%) endorsed auditory hallucinations, and the following scales were elevated: Defensive Avoidance (83%) Intrusive Experiences (81%) Dissociation (58%), Anxious Arousal (53%), Depression (50%). Dissociative symptoms endorsed most frequently included: (1) absent-mindedness, (2) not feeling like your real self, (3) feeling things weren't real, (4) feeling like you're in a dream, (5) daydreaming, and (6) not being able to feel your emotions. Dissociation in torture survivors may be better understood within the ICD-10 construct of dissociation.

**Values, Addiction and PTSD: Integrating Self and Spirituality**

**Workshop (practice)**

**PDR #8, 3rd Floor**

*Young, Helena, MS, VA Sierra Nevada Health Care System/The National Center for PTSD, Palo Alto HCS; Donovan, Beverly, PhD, DVA Medical Center; Padin-Rivera, Edgardo, PhD, DVA Medical Center; Drescher, Kent, PhD, The National Center for PTSD/VA Palo Alto HCS*

Trauma is about conflict and fragmentation; spiritual dissonance relates to the shattering of previously-held assumptions about justice, safety, and meaning. This workshop presents interventions that address spiritually-based self-integration conflicts for combat veterans dually diagnosed with PTSD and substance abuse. Two VA treatment programs (a partial hospitalization and outpatient intervention) in different regions of the country demonstrate the importance of spiritual issues to PTSD recovery, and ways to incorporate spiritual concerns into PTSD treatment. This workshop will examine the differences between religion and spirituality, ways to promote the exploration of values, barriers to goal-setting, forgiveness of self and others, grief and loss, and development of spiritual resources. The presentation incorporates concepts from Hayes' Acceptance and Commitment Therapy (ACT). Values definition and barriers to goal (e.g., sobriety) endorsement are discussed from the therapeutic perspective of confrontation of emotional avoidance. Meaning-making is conceptualized as comprehensibility (the ability to make sense of loss within an existing worldview) as well as benefit-finding (the discovery of significance vis-à-vis a new appreciation for life and the value of relationships). Assessment of treatment utility is directed towards changes in multidimensional aspects of spirituality and quality of life. Handouts detailing practical application of these concepts will be provided.

**Treatment of BPD as a Disorder of Trauma, Attachment and Dissociation**

**Workshop (frag)**

**PDR #9, 3rd Floor**

*Howell, Elizabeth, PhD, Institute Psychoanal. Study Trauma & Dissociation; Blizard, Ruth, PhD, Institute Psychoanal. Study Trauma & Dissociation*

This experiential workshop is intended for clinicians at all levels of experience who treat complex trauma survivors. Accumulating evidence indicates that borderline personality has its etiology in complex, chronic trauma, neglect and double-bind relationships in the family of origin. An understanding of these etiological factors helps to form a framework for treatment of this often bewildering and challenging disorder. The hallmarks of BPD, namely, affect dysregulation, fear of abandonment, idealization and devaluation, explosive rage, and self-mutilation, will be examined in light of recent research on neurobiology, attachment, and dissociation. These characteristics will be explained as manifestations of dissociative fragmentation resulting from neurobiological state changes, disorganized attachment, traumatic reenactment, post-traumatic magnification of perceived threat, and avoidance of overwhelming memories. A relational approach to treatment, based on an understanding of the traumatic origins of these characteristics, will be demonstrated. Role-play of therapeutic interactions will be used to illustrate the empathic confrontation of destructive and self-defeating behavior. We will demonstrate how to marshal patients' strengths and overcome resistance to change by reframing these behaviors as initially adaptive responses to trauma with ultimately maladaptive consequences.

## Saturday, November 1

### Lessons from Auschwitz: Making a New Life and Sharing a New Meaning

**Workshop (frag) Adams Ballroom, 6th Floor**

*Kudler, Harold, MD, Duke University, Durham VA Medical Center; Fried, Hedi, MA, Stockholm Institute of Teachers' Education; Albeck, Joseph, MD, Harvard University*

A survivor shares her own experiences of adapting to a new life as well as the lessons she has learned regarding the psychology of the individual and the pedagogical methods that best promote this knowledge. Questions to be addressed include: What happens when silence prevails? How can trauma be worked through? Why do some people adapt easier than others? What are the salutogenic aspects of surviving trauma? Lessons learned about the psychological mechanisms behind the Holocaust will be reviewed such as the role of prejudices, the tendency to agree with the majority, the belief in one's own invulnerability, and the fine line between good and evil within all humans. Methods to teach about the Holocaust will be shared to include: Living History, the Authority established by the Swedish Government, the curriculum offered by the Stockholm Teachers University and the speaker's own program. Only after the trauma has been worked through can the survivor arrive at a new meaning for life. The act of advancing knowledge about the trauma and about the lessons learned can give such meaning to survivors of any trauma.

### Pediatric Illness Injury: Models for Treating Traumatic Stress

**Workshop (child) Parlor B, 6th Floor**

*Kazak, Anne, PhD, The Children's Hospital of Philadelphia; Saxe, Glenn, MD, Boston Medical Center; Stuber, Margaret, MD, University of California at Los Angeles*

Understanding child and family responses to pediatric illness and injury from a traumatic stress framework is a relatively recent development with growing empirical support. An integrated model will be presented that conceptualizes illness and/or injury as potentially traumatic events with short and long-term opportunities to intervene to prevent or reduce traumatic stress outcomes. Examples of interventions will be discussed in detail, drawing on two case presentations. The importance of acute neurobiological intervention and treatment that impacts the child's social environment will be illustrated in the case of a 10-year-old boy burned on 30% of his body while playing with matches. Treatment during his 6-week hospitalization incorporated the impact of multiple surgeries that occur in the context of family conflict and divorce. A psycho-educational group intervention for parents of young children and adolescents who are undergoing organ transplantation will be also be described. These patients experience multiple invasive procedures, and parents who often feel helpless. Preventative approaches to the family to increase self-efficacy and decrease fear and helplessness are key in the treatment. A guided discussion among the presenters and audience will link the cases and model with recommendations for treatment more broadly in pediatric healthcare.

### Closing Plenary Address

**4:00 p.m.–5:15 p.m.**

#### The Emerging Psychobiology of Trauma-Related Dissociation

**Plenary (frag) Grand Ballroom, 4th Floor**

*Nijenhuis, Ellert, PhD, Mental Health Care Drenthe, Assen Cats-Palm Institute, Zeist Research School Psychology & Health*

**Participants are advised that the presentation will involve slight potential for some distress (a video fragment of a patient who has many traces of self-mutilation, mainly burns and cuts, will be shown).**

Exciting recent studies on the psychobiology of trauma-related dissociation greatly enhance our understanding of how the body and the mind respond to overwhelming threat. This presentation reports the crucial findings of these innovative neuroimaging and psychophysiological studies of chronically traumatized and highly dissociative individuals. MRI studies of complex dissociative disorder patients reveal major brain abnormalities that correlate with the severity of dissociation and traumatization. Experimental neuroimaging and psychophysiological studies have tested the hypothesis that different types of dissociative parts of the personality have distinct psychobiological responses to perceived threat cues. Dissociative parts that are fixated on traumatic memories display reactions that are mediated by the action system of defense to bodily threat from a person (e.g., amygdala and insula activation). Parts that engage in flight, freeze, and fight involve sympathetic dominance, and parts that exhibit total submission seem to be controlled by parasympathetic dominance. Dissociative parts that are mediated by action systems for functioning in daily life inhibit cognitive and emotional awareness of threat cues, and block bodily feelings. This presentation will show that the understanding of dissociation as a structural division of the personality opens exciting avenues in the psychobiological study of traumatization and has profound clinical implications.