

Thursday, October 30

Opening Plenary Address

**Thursday, October 30
1:00 p.m.–2:15 p.m.**

Surviving Violence and Shattering Silence

Plenary (frag) Grand Ballroom, 4th Floor

Prescott, Laura, BA, Sister Witness International Inc.

Participants are advised that the presentation will describe the sequelae of sexual violence and retraumatization in some detail that may be distressing for some listeners.

The incidence of childhood sexual and physical abuse in the lives of women across services sectors is so pervasive it has been described as a “normative female experience.” This presentation uses a first-person account to describe these experiences for women nationally and internationally illustrating the need for trauma-sensitive, client-directed approaches.

Concurrent Sessions—Thursday, October 30

**Thursday Concurrent Sessions
2:30 p.m.–3:45 p.m.**

Community and Milieu Trauma Treatment

Consultation (practice) Wabash Room, 3rd Floor

Bloom, Sandra L., MD, Community Works

Providing trauma-informed services within inpatient and outpatient mental health treatment settings, residential treatment programs for children, substance abuse programs, child protection services, victims’ services and domestic violence shelters is a critical component necessary for recovery. This consultation will focus on discussing the necessary elements for creating the proper milieu context for trauma-informed treatment.

**Memory and Identity in PTSD:
A New Perspective on Trauma and Treatment**

Forum (frag) Grand Ballroom, 4th Floor

Brewin, Chris, PhD, Subdepartment of Clinical Health Psychology, University College London; Friedman, Matthew, MD, PhD, National Center for PTSD

Many central aspects of PTSD, such as the coherence of the diagnosis, how traumas can be relived in the present, and what it means to “process” or “transform” a trauma memory, are poorly understood at present. A major reason is that PTSD appears to incorporate two quite separate sets of processes. One of these is concerned with specific reactions to extreme threat, including the activation of the HPA axis and the release of catecholamines and stress hormones. The effects on brain structures such as the prefrontal cortex, hippocampus, and amygdala promote the encoding of long-lasting image-based memories but interfere with the encoding of verbal or narrative memories. The construction of adequate verbal memories containing contextual information is a form of fast learning necessary to represent the trauma as a past event and inhibit the repeated reliving of the trauma. Retrieval competition then takes place between these verbal memories and image-based memories in the presence of trauma cues. The second set of processes is concerned with the challenge the trauma poses to the victim’s identity, either by undermining positive identities or reinstating previous unwanted identities. This challenge can be overcome

with a special form of slow or interleaved learning that enables positive identities to compete more effectively for retrieval. The most parsimonious explanation of spontaneous recovery and treatment suggested by recent research is that “trauma processing” leaves original trauma memories intact and instead involves the construction of alternative, verbal memories. Both these new memories, and new or pre-existing positive identities, are then helped to compete more effectively for retrieval in the presence of reminders of the traumatic event. Reference Brewin, C.R. (2003 Yale University Press).

Helping Children Overcome PTSD and Shame Associated with Sexual Abuse

Master (child) State Ballroom, 4th Floor

Deblinger, Esther, PhD, University of Medicine & Dentistry of N.J., School of Osteopathic Medicine

Child sexual abuse is widespread and often extremely deleterious in its psychological impact. The purpose of this master clinician presentation is to provide information on empirically validated interventions designed to help children who have suffered sexual abuse. The presenter will very briefly present the findings of a series of randomized trials documenting the efficacy of the treatment approach to be presented. The development of therapeutic collaborative relationships with both the child and the nonoffending parent(s) will be emphasized, along with the establishment of structure and goals for treatment. Cognitive behavioral interventions specifically designed to help children overcome PTSD and related feelings of shame and self blame will be presented. Specific interventions include coping skills training, gradual exposure and processing exercises, educational work, personal safety skills training and exercises to enhance parent child communication. In addition, creative strategies for helping clients overcome avoidance of traumatic memories and reminders will be presented. Developmental considerations will also be discussed. The practical implementation of the interventions will be illustrated through interactive discussion, specific case examples, slide presentations, audiotape examples and role-plays.

PTSD Following Injury: Explaining Variant Findings

Panel (assess) Parlor A, 6th Floor

O’Donnell, Meaghan, MA, University of Melbourne; Bryant, Richard, PhD, University of New South Wales; Marshal, Grant, PhD, RAND; Zatzick, Douglas, MD, University of Washington; Schnyder, Ulrich, MD, University Hospital Zurich

In recent years, a number of longitudinal studies of PTSD in physically injured trauma survivors have been published with surprisingly variant findings. The aim of this panel is to offer an integrated discussion of this research, with a focus on possible explanations for these apparent discrepancies. Panel discussants are key researchers in this area and include Richard Bryant, Arieh Shalev, Ulrich Schnyder, Mark Creamer, Douglas Zatzick and Grant Marshal. To achieve this, relevant recent research will be reviewed and possible explanations for the variant findings will be explored. Although the discussion will focus on PTSD research, it will also have relevance for other psychological injury research. Key components of the discussion will include an examination of assessment approaches, sampling procedures, and data analytic methods across prospective investigations. The specific topics of traumatic brain injury, peritraumatic substance intoxication/administration, phenomenological overlap between organic and psychogenic symptoms, and considerations surrounding the inclusion of ethnoculturally diverse trauma survivors will be examined. Discussion will include recommendations for future research and a consensual approach to addressing these issues will be explored.

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Development of Treatment Guidelines for Survivors of Clerical Abuse

Panel (practice) Red Lacquer Room, 4th Floor

Keane, Terence, PhD, National Center for PTSD; McMackin, Robert, EdD, Massachusetts Department of Public Health; Thorp, Barbara, MSW, Archdiocese of Boston; Sassani, John, Office of Spiritual Development, Archdiocese of Boston

Child sexual abuse by clergy is a betrayal of trust that can leave profound psychological, emotional, and spiritual scars on the survivor, his or her family and the community. The Archdiocese of Boston has supported the treatment of over 200 survivors for clerical sexual abuse over the past two years. In order to make informed decisions on the proper care for survivors of clerical abuse the Archdiocese of Boston established a workgroup, composed of mental health and pastoral care professionals, to develop Guidelines of Care or Best Practices that can inform the treatment decision making process. This panel discussion includes the co-chairs of the Archdiocesan Workgroup, Terence Keane, PhD and Barbara Thorp, MSW and the workgroup coordinator, Robert McMackin, EdD. The panel will discuss the workgroup process and how this has help inform the treatment offered to survivors by the Archdiocese of Boston.

Culture, Trauma and Domestic Violence: Current Research, Critical Issues

Panel (culture) Adams Ballroom, 6th Floor

Warshaw, Carole, MD, Domestic Violence & Mental Health Policy Initiative, Cook County Hospital; Yoshihama, Mieko, PhD, University of Michigan; Perilla, Julia, PhD, Georgia State University; Jenkins, Esther, PhD, Chicago State University

Domestic violence cuts across cultures and communities yet research on the range of issues faced by diverse communities in responding to the traumatic sequelae of domestic violence and on interventions designed to address these concerns is limited. This presentation will 1) examine the intersection of culture and cultural discrimination in shaping women's experience of trauma and domestic violence; 2) review the current status of research on trauma and domestic violence among women from the African American, Latino and Asian Pacific Islander communities; and 3) describe culturally-specific models for addressing trauma in the context of domestic violence at both the individual and community level. Presentations will include perspectives from the National Latino Alliance to Eliminate Domestic Violence, the Institute on Domestic Violence in the African American Community, the Asian Pacific Islander Institute on Domestic Violence and the National Network on Behalf of Battered Immigrant Women as well as from community-based programs. Discussion will focus on differences and similarities within and across cultures, the layers of experience that influence women's responses to trauma and domestic violence, and the need for integrated models to create community as well as individual change. Suggestions for future research and dialogue on these issues will be discussed.

Broken Spirits: Post-Traumatic Injury to the Self

Symposium (frag) Withdrawn

Wilson, John, PhD, Cleveland State University; Gregurek, Rudolf, MD, Clinic for Psychological Medicine, University of Zagreb

Trauma impact to optimal states... can result in a continuum of self-fragmentation... of post-traumatic interpretation... presents new conceptual data on how self-dissociation occurs and results in 11 distinct typologies of post-traumatic personality formation.

Broken Spirits: Post-Traumatic Injury to the Self

Courtois, Christine, PhD, Psychiatric Institute of Washington, Private Practice; Wilson, John, PhD, Cleveland State University; Williams, Mary Beth, PhD, Trauma Recovery Education and Counseling Center; Vukusic, Herman, MD, University of Zagreb Clinic for Psychological Medicine

This symposium will examine the various forms of self-fragmentation occurring after severe trauma experiences. First, trauma's impact to the six major components of the self (i.e., coherence, continuity, autonomy, vitality, etc.) are examined. Second, based on recent research, typologies of post-traumatic self-alterations are described as falling on an adaptational continuum from fragmentation and severe dissolution to integrated, re-synthesized, self-actualizing modes of functioning. Third, the processes and mechanisms of the various pathways of self-fragmentation following trauma are described in detail. Fourth, the integrative processes of self and identity are explained in terms of identity-diffusion, identity integration, self-continuity, and self-discontinuity in ego-processes. Fifth, the inadequacy of understanding PTSD by the constraints of DESNOS, Complex PTSD and the current DSM-IV diagnostic criteria are discussed. Finally, the implications for treatment and research are presented

A Jungian Analysis of Self-Fragmentation/Integration Following Trauma

Vukusic, Herman, MD, Clinic for Psychological Medicine

Recent analytic investigation and research has identified the criteria to conceptually define the Trauma Affect (TA) and Trauma Complex (TC) within a Jungian framework. The 10 criteria which operationally define the Trauma Complex will be presented. It will be suggested that in order to understand self-fragmentation and integration following trauma, a model of personality processes which employs a super-ordinate construct such as the Trauma Complex, extends the understanding of post-traumatic impacts to the self beyond the notions of complex PTSD, desires and similar conceptualization of traumatized states.

Beyond DESNOS and Complex PTSD

Williams, Mary Beth, PhD, Trauma Recovery Education and Counseling Center

This presentation will present an overview of the conceptualization of PTSD as a complex and prolonged stress response syndrome. It will be highlighted that both the DESNOS and Complex PTSD criteria do not sufficiently delineate the self-structure, personal identity or ego. Further, without a clearly established model of the self-structure, it is not possible to specify the different ways that the self undergoes dissolution and fragmentation. This presentation will lay a foundational, theoretical framework for understanding fragmentation and integration of the self following trauma.

Trauma and Comorbid Psychiatric Disorders in Diverse Populations

Symposium (assess) Parlor H, 6th Floor

Brady, Stephen, PhD, Boston University; Osterman, Janet, MD, Boston University School of Medicine

The symposium presenters will describe their clinical experiences and the results of a number of recent studies in which they have participated that have examined trauma, psychiatric disorders and comorbidity. They will also call into question the validity and limitations of the PTSD diagnoses which does not adequately reflect current knowledge pertaining to the impact of stress and trauma on a range of symptoms and is the only diagnoses which requires a precipitating (life threatening -Criteria A) event in order for a diagnosis to be made. The presenters will describe their clinical work and research pertaining to urban patients in the U.S. with severe mental illness, women with AIDS, and respondents in post-conflict settings in

Algeria, Cambodia, Ethiopia and Gaza. The data are quite compelling that PTSD frequently co-occurs with other diagnosable disorders particularly depression, substance abuse and other anxiety disorders (social phobia, simple phobia, panic disorder, and generalized anxiety disorder). It is also apparent that even without a criterion A event required to make a diagnoses of PTSD, many patients otherwise meet the criteria for a trauma related disorder. The Chair of the Symposium, Dr. Stephen Brady, will describe his clinical work and the results of two modest studies he has completed which examine PTSD in a sample of urban men and women with schizophrenia, bipolar illness and comorbid substance abuse disorders. He will also describe a study which examined the traumatic life experiences of a sample of U.S. women with AIDS. Dr. de Jong will examine the results of a study he and his colleagues undertook to assess mood disorder, somatoform disorder, posttraumatic stress disorder and other anxiety disorders in a random sample of over 3000 respondents from Algeria, Cambodia, Ethiopia and Gaza. Dr. Osterman who will serve as the Discussant for the symposium will raise questions about the validity of our current western diagnostic constructs and the trend to diagnose multiple comorbid disorders.

Should the Stressor Criterion Be Used Exclusively for PTSD?

de Jong, Joop, MD, PhD, Transcultural Psychosocial Organization; Osterman, Janet, MD, Boston University School of Medicine; Brady, Stephen, PhD, Boston University School of Medicine

The CIDI 2.1 was used to assess mood disorder, somatoform disorder, posttraumatic stress disorder (PTSD), and other anxiety disorder (OAD) in a random sample of 3048 respondents from communities in Algeria, Cambodia, Ethiopia, and Gaza. The frequency of exposure to armed conflict-associated violence was 92% in Algeria, 81% in Cambodia, 79% in Ethiopia and 59% in Gaza. Respondents with history of armed conflict-associated violence, most frequently reported PTSD, 19% in Ethiopia to 40% in Algeria; while respondents without exposure to armed conflict-associated violence, most commonly reported OAD: 3% in Ethiopia to 30% in Cambodia. Somatoform disorders were least reported: 0.4% in Ethiopia (no exposure) to 8.7% in Algeria (with exposure). Compared to findings in the West, we found low rates for comorbidity. The 2 most common forms of comorbidity were PTSD with other anxiety disorder and PTSD with mood disorder. Reported rates of disorder were highest in Algeria and lowest in Ethiopia. Experience of armed conflict-associated violence was associated with higher rates of disorder and ranged from (adjusted Odds Ratio (aOR)) 2.1, (95% confidence interval (CI), 1.4-2.9 for anxiety in Algeria to (aOR) = 10.0, (CI) 5.3-16.7 for PTSD in Gaza. A relationship between armed conflict-associated violence, psychiatric disorder, and comorbid psychiatric disorder was established in settings of armed conflict. A 3 to 10-fold increase of PTSD was found among those exposed to violence. We also found a 1.2 to 6-fold increase of mood disorder and other anxiety disorder. Disability was more associated with mood disorder and anxiety disorder than with PTSD. This calls for a paradigm shift among professionals who focus on primarily on PTSD within trauma rehabilitation or intervention programs to address the impact of traumatic stress on mood disorders and other anxiety disorders. One wonders whether it is still justified to use the stressor criterion exclusively for PTSD.

Comorbidity: Real or Artifact

Osterman, Janet, MD, Boston University School of Medicine, Boston, MA; de Jong, Joop, Transcultural Psychosocial Organization; Brady, Stephen, PhD, Boston University School of Medicine

PTSD is typically, in western settings, associated with a range of comorbid disorders. The most commonly reported co-morbid disorder in the National Co-morbidity study conducted in the US include mood disorders (major depressive disorder and dysthymia), alcohol and substance abuse disorders, and other anxiety disorders (social phobia, simple phobia, panic disorder, and generalized anxiety disorder). Mood, anxiety, and substance abuse disorders tend to clus-

ter independently of PTSD. The diagnostic nomenclature, whether the ICD or DSM system, has been developed primarily through phenomenology. A review of the neurobiology of PTSD, anxiety, and depression raises questions about the validity of our current western diagnostic constructs and the trend to diagnose multiple co-morbid disorders. In addition, a review of diagnostic symptom criteria for PTSD, anxiety disorders, and mood disorders reveal much overlap. A higher level of endorsement for PTSD symptoms increase the likelihood of endorsing mood or other anxiety disorder symptoms, raising questions of true co-morbidity vs. severity. Questions of pre-morbid disorders are critical to understand trauma exposure and subsequent risk for trauma-related disorders, and associated "co-morbid" disorders.

PTSD and Trauma in Special Populations

Brady, Stephen, PhD, Boston University School of Medicine; de Jong, Joop, MD, PhD, Transcultural Psychosocial Organization; Osterman, Janet, MD, Boston University School of Medicine

Post-Traumatic Stress Disorder continues to be under diagnosed among individuals with severe mental illness and substance abuse. In a convenience sample of 64 patients with severe mental disorders being treated at an urban outpatient clinic, 24% met full criteria for PTSD based upon a comprehensive assessment protocol with only 3% were diagnosed with PTSD in the medical record (Cochrans Q= 11.267, df 1, p.001). In contrast, there was a high rate of diagnostic agreement for psychotic and affective illnesses as well as substance abuse. More attention needs to be given to utilizing a standard protocol for diagnosing PTSD among severely mentally ill individuals because even highly skilled diagnosticians miss the complex presentations of symptoms with which these patients present for treatment. In a systematic review of the medical record for a sample of the first 100 women with AIDS enrolled in a state subsidized healthcare organization the presenter and his colleagues collected extensive data about the nature and extent of their traumatic life experiences. Virtually all of the women (95%) had documentation of a history of childhood sexual abuse, rape, domestic violence and other physical assault. The author will review these data and make recommendations regarding the assessment and diagnosis of trauma by medical providers treating women with AIDS in the U.S.

Survivors and the News: Interactions That Work

Workshop (train)

Parlor B, 6th Floor

Scherer, Migael, BA, Dart Center for Journalism and Trauma, University of Washington; Boggs, Jim, PhD, EffectiveArts; Correa, Fanny, MSW, Separation and Loss Services, Virginia Mason Hospital; Shapiro, Bruce, BA, Dart Center for Journalism and Trauma and Yale University

When news breaks, reporters look for expert sources who can give them accurate information as well as survivors who can put a face on the traumatic event for readers and viewers. Yet clinicians are wary—often with reason—to expose survivors to news media. Given that news media shapes how the community sees and responds to trauma and that survivor stories are important, is there an ethical way to lower the barrier between reporter and survivor? This workshop provides an experiential platform for exploring this question. Through the same technique used to teach reporters how to interview victims of trauma, you'll observe two live interviews between a real reporter and a victim/survivor who is portrayed by a professional actor. Each interview will be followed by a debriefing led by a survivor, a journalist, and a victim advocate. After both interviews, the victim-actor will join a general discussion to help identify preliminary guidelines for constructive interaction with journalists.

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Application of Dialectical Behavior Therapy to Trauma-Related Problems

Workshop (practice) PDR #9, 3rd Floor

Wagner, Amy, PhD, University of Washington, Department of Psychiatry & Behavioral Sciences; Jakupcak, Matthew, PhD, Seattle VA Hospital; Melia, Kathleen, PhD, Clinical Psychologist, Private Practice, Concord Wellness Center

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

Succeeding in the Political Process: A Primer for Traumatologists

Workshop (culture) Crystal Room, 3rd Floor

Berkowitz, Steven, MD, Yale University, School of Medicine; Harris, William, PhD, KidsPac; Harris, David, MEd, Columbia University

The presentation will describe and review the importance and utility of working with local, state, and national political processes for clinicians and researchers who practice in the field of psychological trauma. An academic, a lobbyist, and a city official will focus on the why, what, and how of embedding traumatology in public policy. Policy analysis is the study of what's going on in some area of inquiry. Political analysis is the study of why it is going on. If, as a senior administration official said recently, "Ideology trumps data," how can a trauma clinician/researcher access government resources to support their work. An elected wants to know: What do traumatologists do? Who needs trauma services? What are their demographics? Why do they need your services? How do they present? Where? Who pays? Does what you do make any difference? How do you know? What happens to the client if no services are provided? Learn how to apply clinical experience to working with elected officials and their staffs, how a traumatologist accesses the political system, how to take a political history, the context of your meeting, the utility for electeds, the rationale for your ask, and the timing/sequencing of your political approach.

Protecting Children from Inheriting the Effects of Violence

Workshop (child) Parlor F, 6th Floor

Dubrow, Nancy, PhD, Taylor Institute; Peddle, Nancy, PhD, Taylor Institute/Prevent Child Abuse America; Mandour, Mohamed, MD, Palestine Red Crescent Society; Jouda, Amal, PhD, Al-Aqsa University Gaza/Palestine Red Crescent Society; Awwad, Elia, PhD, Palestine Red Crescent Society

For over two years, civilians, including children, youth and families have been caught up in the Palestinian uprising against Israeli military occupation. They have endured death, physical and psychological injury, economic hardship, and destruction of property, curfews and closures. According to UNICEF (2001), almost all the Palestinian children, an estimated 1.5 million, are being exposed to violence either directly through physical attacks and harassment or indirectly by watching television and hearing horrific stories or a combination of these events. The Taylor Institute and the Palestine Red Crescent Society have worked together for fifteen years to

implement various mental health projects. This workshop will be presented jointly by Taylor Institute staff and our Palestinian colleagues. We will share our experience in developing culturally relevant curriculum for multi-disciplinary groups such as teachers, social workers and youth workers and implementation of community-based activities and programs for children, youth and families.

Community-Based Programs for Youth Traumatized by War and Other Violence

Workshop (child) PDR #4, 3rd Floor

Chew, Marion, PhD, Center for Multicultural Human Services; Sanderson, Andrea, MS, Center for Multicultural Human Services; Fisher, Katherine, MSW, Center for Multicultural Human Services

This training features the work of a National Child Traumatic Stress Network site that serves many immigrant and refugee families. These approaches are appropriate interventions for cultural and ethnic minorities as well as the general child and adolescent population who have experienced trauma such as abuse, domestic violence, community violence, war or resettlement. The presenters will review strategies for working with traumatized children and adolescents in a variety of community settings including schools, community centers, religious meeting places and other facilities. They will share successful methods of approaching and engaging individuals and/or communities in need. Participants will become familiar with the techniques of designing programs to address the specific needs of the recipients. This portion of the workshop will focus on the consultative role of mental health professionals who assist schools in coping with crises and disasters. Examples of specific therapeutic activities will also be presented.

Integrative Psychoeducation: A Community Trauma Intervention

Workshop (commun) PDR #5, 3rd Floor

O'Neill, Peggy, PhD, New York State Psychiatric Institute, The Center for Family Education and Research; Lukens, Ellen, PhD, Columbia University School of Social Work, New York State Psychiatric Institute, CFER; Thorning, Helle, MS, CSW, New York State Psychiatric Institute, Center for Family Education and Research; Cecutti, Jaime, MS, CSW, New York State Psychiatric Institute, Center for Family Education and Research

September 11, 2001, prompted an urgent need to develop and implement effective trauma-related intervention and prevention models for the general public. This is particularly salient in our changed society characterized by evolving terrorist threats, financial repercussions and the reality of living in a country at war. In collaboration with five urban community-based agencies, the intervention is adapted to be culturally, linguistically and circumstantially relevant. The collaborative process of assessment, curriculum development, training and evaluation incorporates attention to the needs and experiences of providers working in the shared context of community trauma. This brief four or twelve session intervention draws on evidence-based theory and method, rooted in ecological systems theory, social learning theory, cognitive behavioral theory, and models of resiliency and social support. Key integrative psychoeducation principles include: resilience in the context of community trauma; collaborative community of care across systems; information dissemination-knowledge as power; and culturally relevant processes and content. These strengths-based groups are designed to create safety within and outside of the group; to help participants develop emotion management and care skills; to facilitate grief processes; and, throughout, to assist participants in identifying and building resiliency.

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4:00 p.m.–5:15 p.m.

Clergy Abuse and Public Trauma: News Coverage, Survivors, and Healing

Panel (train) Monroe Ballroom, 6th Floor

Spratt, Margaret, PhD, Dart Center for Journalism and Trauma/University of Washington, Seattle; Clohessy, David, Survivors Network of Those Abused by Priests (SNAP), Dart Center; Kennedy, Eugene, PhD, Professor Emeritus, Loyola University, Dart Center for Journalism and Trauma; Lieblich, Julia, Dart Center for Journalism and Trauma

The clergy abuse scandal received widespread coverage in media outlets worldwide, though some survivors and victim advocates argue that the healing process, and the victims' point of view, has garnered little public attention. This panel discussion brings together a journalist, a victim's advocate, and a nationally-known religion writer and psychology professor to consider the effect news coverage may have on victims of clergy abuse. The panel will explore how such coverage may be improved, in part by better addressing the connection between healing, the spiritual beliefs of survivors, and betrayal by trusted church officials.

Traumatic Loss and Reconstruction of the Assumptive World

Panel (frag) Crystal Room, 3rd Floor

Landsman, Irene, PhD, Private Practice; Kauffman, Jeffrey, MA, MSS, Private Practice; Solomon, Roger, PhD, Critical Incident Recovery Resources Inc.; Figley, Charles, PhD, Florida State University School of Social Work and Traumatology Institute

Practitioners and theorists from the fields of trauma and bereavement are exploring ways in which formerly disparate approaches may be integrated in a comprehensive conceptualization of traumatic loss. The concept of the assumptive world and its disintegration arises from work in both bereavement and trauma. This crisis constitutes a major element in the psychological disturbance following traumatic loss. Three presentations and an overview highlight recent advances in theory and practice. A review and integration of theory from both traumatology and thanatology highlights important differences among approaches to understanding world assumptions, distinguishing between concepts of "ordinary" and "existential" meaning, with implications for both despair and transcendence. The first clinical perspective explores traumatic sequelae in a psychodynamic framework: lost assumptions constitute a loss of part of the self; fragmentation and efforts to re-integrate the self characterize the phenomenology of post-traumatic experience. Another clinical perspective identifies traumatic interference with restoring or revising world assumptions, illustrating treatment directly focused on facilitating adaptive integration. Finally, an overview and commentary on these presentations is given, highlighting ways in which theory and practice related to trauma and grieving have informed and enriched one another, and the emergence of an integrated approach to conceptualizing and treating traumatic loss.

Reliving the Past: The Long-Term Consequences of Preverbal Trauma

Panel (child) State Ballroom, 4th Floor

Endorsed by the Child Trauma Special Interest Group

Kaplow, Julie, PhD, Center for Medical and Refugee Trauma/Boston University Medical Center; Saxe, Glenn, MD, FRCP, Center for Medical and Refugee Trauma/Boston University Medical Center; Putnam, Frank, MD, Center for Safe and Healthy Children/Cincinnati Children's Hospital; Pynoos, Robert, MD, MPH, National Center for Child Traumatic Stress/David Geffen School of Med, UCLA

There is a great need to better understand the impact of traumatic events very early in life on the course of children's future develop-

ment. This panel discussion will focus on the manifestations of traumatic stress in children who have no explicit (declarative) memory for the trauma because of the very early age at which the trauma occurred. To exemplify this phenomenon, we will present an intriguing case of an 11-year old girl who was witness to the murder of her mother by her father at the age of 2. The girl had no recollection of this incident and no significant mental health problems until age 10 when she became severely symptomatic in response to a traumatic reminder. This case illustrates the dramatic impact that preverbal traumatic memories can have on children's later functioning and speaks to the importance of assisting toddlers and preschoolers in the processing of traumatic events. The goal of the panel discussion is to utilize this case presentation as a starting point for providing different perspectives on the issue of preverbal traumatic memory formation and the profound influence that these memories can have over the course of development.

Collaborative School-Based Interventions with Refugee Youth

Panel (commun) PDR #5, 3rd Floor

Liataud, Joan, PsyD, International Family, Adult and Child Enhancement Services; Black, Mary, MA, International FACES; Rydberg, Thad, MA, International FACES; Pagones, Paul, MEd, International FACES; Quensen-Diez, Erica, MA, International FACES

This panel discussion will focus on alternative interventions with traumatized refugee youth through collaborations with Chicago Public Schools (CPS) in three distinct school environments: a school-based health center, a refugee student "Newcomers Center" and an ESL classroom. Traumatizing events have led these students and their families to flee their countries of origin, forcing them to face cultural, societal and educational differences when they are highly vulnerable. Most refugee students have not had the opportunity to address their trauma; their traumatic histories consequently impact their performance and behavior at school. The need to educate teachers in recognizing the signs of trauma in their students initiated a collaboration between CPS and the International FACES program. Through the use of in-services, creative arts based interventions in the classroom and family support, the International FACES program supports the psychic healing of refugee youth as they integrate into their new lives in the United States.

Etiological Factors in Youth PTSD: The Role of Peritraumatic Reactions

Symposium (child) Parlor A, 6th Floor

Endorsed by the Child Trauma Special Interest Group

Rodriguez, Ned, PhD, Private Practice, Hathaway Children's Clinical Research Institute; Weiss, Daniel, PhD, University of California, San Francisco

While researchers have studied adults' peritraumatic reactions (PR), few have explored the PR-PTSD link in youth. Presentations: investigate PR-PTSD relationships; report some of the first available data on youth peritraumatic dissociation; and compare findings across prospective and retrospective studies of child/adolescent survivors of acute and chronic trauma types.

Peritrauma Factors and Posttraumatic Stress in Injured Children

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

Data from a prospective study of posttraumatic stress in injured children will be presented to examine the relationship between peritrauma factors and later ASD and PTSD symptoms in children. We enrolled 243 children (age 8–17) admitted to a large urban pediatric hospital for injuries sustained as a pedestrian, bicyclist, or vehicle passenger. Peri-trauma factors were assessed as soon as possible post-injury (50% within one week), acute symptoms were

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assessed within one month of injury, and for 177 children (64%) PTSD symptoms were assessed at least four months post-injury. Peri-trauma factors included objective and subjective measures of exposure severity and peri-trauma reactions (including dissociation). Objective elements of the crash and of emergency medical treatment were more strongly associated with ASD symptoms than with later PTSD symptoms. Subjective life threat, self-reported exposure to traumatic elements of the crash and its aftermath (such as a frightening ambulance ride or others' injuries), as well as peri-trauma fear and horror were all associated with ASD and PTSD symptoms. Peri-trauma dissociation was strongly associated with other ASD symptoms; both were predictive of later PTSD symptom severity. Implications of these results for understanding the etiology of post-traumatic stress after acute child trauma will be discussed.

Peritraumatic Reactions/PTSD in Children Exposed to Domestic Violence

Gaba, Rebecca, PhD, Children's Institute International; Seilikovich, Irma, MA, Children's Institute International; Ross, Leslie, PsyD, Children's Institute International; Foy, Patrick, BS, Children's Institute International; Foy, David, PhD, Graduate School of Education and Psychology, Pepperdine University

Relationships between severity of domestic violence exposure and PTSD symptoms in children have been addressed in several recent studies. However, the extent to which children's reactions during exposure to domestic violence are related to the development of PTSD has yet to be established. Perceived life-threat may be a critical element in linking immediate reactions to increased risk for PTSD in children living in homes where intimate partner violence is occurring. The present study is designed to examine this relationship in children (n= 57), ranging in age from 5 to 10 years (X= 7.9), receiving services at our agency. We used standard instruments with established psychometric properties, the Conflict Tactics Scale and the Los Angeles Symptom Checklist, for assessing domestic violence exposure, including perceived life-threat, and PTSD severity. Preliminary analyses revealed that 41% of our sample reported life-threat during their experiences of domestic violence. Comparing mean PTSD severity scores between children reporting life-threat and those who did not, we found no significant differences between the groups. However, a significant positive correlation was found between CTS severity and PTSD severity (r=.23, p<.05). Results will be updated and discussed in terms of our understanding of PTSD etiology in children exposed to domestic violence, and clinical implications for early intervention efforts.

The Children's Peritraumatic Experiences Questionnaire

Veitch Wolfe, Vicky, PhD, London Health Sciences Centre; Birt, JoAnn, PhD, London Health Sciences Centre

The CPEQ assesses DSM-IV PTSD Criterion A2 (peritraumatic "intense fear, helplessness, and horror"), and can be used to assess peritraumatic reactions immediately after a trauma or recollections of peritraumatic reactions at subsequent points, such as when PTSD is assessed. CPEQ psychometric properties were investigated, based upon comparisons of three groups of youth ages 8 to 16 (N = 326; sexually abused, agency-referred, and community controls). For the sexual abuse sample, assessments were conducted up to three years post disclosure, and both peritraumatic reactions and trauma symptomatology were assessed simultaneously. Principal component analyses yielded five scales: Extreme Reactions, Fear/Anxiety, Anger, Dissociation, and Guilt. With the exception of Guilt, all scales showed strong internal consistency (alphas > .80) and discriminated the sexually abused from the comparison participants. As evidence of construct validity, CPEQ Extreme Reactions predicted PTSD and Dissociative Reactions predicted Dissociative Symptoms, suggesting a link between specific peritraumatic reactions and specific trauma symptomatology. Further investigation will examine links between CPEQ Fear/Anxiety and Anger and fear and anger symptoms. The

results highlight the need for further research using the CPEQ subsequent to traumatic events to determine consistency of recollections across time and to examine links between initial CPEQ responses and subsequent symptomatology.

Peritraumatic Dissociation/PTSD: Dissociation Mediation in Youth

Sugar, Jeff, MD, Hathaway Children's Clinical Research Institute; Rodriguez, Ned, PhD, Hathaway Children's Clinical Research Institute and Private Practice; Hunt, Angela, MA, Hathaway Children's Clinical Research Institute; Lajonchere, Clara, PhD, Hathaway Children's Clinical Research Institute

While the co-occurrence of symptoms of PTSD and dissociation has been widely reported in trauma survivors, few researchers have investigated the link between these symptom categories. This study is among the first to investigate the relationship between trauma exposure, including peritraumatic dissociation (PD), post-trauma dissociative symptoms (DS), and PTSD in youth. Working from an information-processing model of PTSD etiology, we reasoned that PD would lead to DS, and that higher levels of DS would complicate the resolution of PTSD and lead to more severe PTSD symptoms. Specifically, we tested the hypothesis that DS would mediate the relationship between PD and PTSD. The sample consisted of 100 multi-ethnic chronically traumatized adolescents residing in a residential treatment center. Assessment incorporated psychometrically standardized measures of trauma exposure, peritraumatic reactions and PTSD (PTSD Index), and DS. Multivariate analysis showed that PD accounted for 32% of the variance in PTSD, with DS accounting for an additional 7% of the variance in PTSD. While DS partially mediated the relationship between PD and PTSD, PD remained the strongest predictor of current PTSD. Implications regarding the etiology of Youth PTSD, Criterion A2 in children and adolescents, and the assessment and treatment of chronically traumatized youth will be discussed.

Early Cognitive Predictors of Posttraumatic Distress Following Trauma

Symposium (clin res) PDR #9, 3rd Floor

Marshall, Grant, PhD, RAND

This symposium will present empirical findings based on prospective studies of persons exposed to diverse traumatic events. Findings will address the importance of early perceptions of personal control, self-blame, and temporal orientation to subsequent posttraumatic distress following trauma exposure. Theoretical and clinical implications will be discussed.

The Role of Self-Blame in the Development of PTSD Symptoms

Schell, Terry, PhD, RAND; Marshall, Grant, PhD, RAND

This prospective study examined predictors of posttraumatic distress using data collected from approximately 400 survivors of community violence requiring hospitalization for injuries. Data were collected in three face-to-face interviews conducted shortly after injury, at 3-months posttrauma and again at 12-month. The assessment battery included measures of pre-event variables (e.g., demographic characteristics, prior exposure to violence, prior use/abuse of alcohol), objective event characteristics (e.g., injury severity), and personal/social coping resource variables (e.g., event attributions, personality constructs, perceived social support). A series of regression analyses revealed that several of these baseline measures were correlated with PTSD symptom severity at 12-months. In particular, victims' attributions of self-blame assessed within days of trauma exposure emerged as an important predictor of 12-month PTSD symptom severity after adjusting for a range of other constructs. In addition, most of the association between self-blame and 12-month PTSD symptoms remained after controlling for respondents' baseline

levels of PTSD symptoms. This suggests that self-blame is not only correlated with immediate traumatic distress but may play an additional role in long-term posttraumatic adaptation. The clinical and theoretical implications of these findings will be discussed.

The Role of Perceived Control in Recovery from Sexual Assault

Frazier, Patricia, PhD, Department of Psychology, University of Minnesota

The purpose of this study was to test a new model of the role of perceived control in recovery from trauma developed by Frazier, Berman, and Steward (2002). Data were collected from female sexual assault survivors (n = 171) at four points postassault from 2 weeks to 12 months postassault. Participants initially were seen at a hospital-based rape crisis program. Consistent with the temporal model of control (Frazier et al., 2002), past, present, and future control were differentially related to posttrauma distress. Specifically, both personal past (behavioral self-blame) and vicarious past (rapist blame) control were associated with higher distress levels. In addition, the belief that future assaults were less likely was more strongly associated with lower distress levels than was future control (i.e., taking precautions to prevent future assaults). Present control (i.e., control over the recovery process) was most adaptive. Hierarchical linear modeling analyses revealed that changes in perceived control were associated with changes in distress, after accounting for change in distress over time (e.g., increases in perceived control over the recovery process were associated with decreases in distress). The data suggest that it is less adaptive to focus on why an event occurred in the past, or even on how a trauma can be avoided in the future, than to focus on aspects of the trauma that currently are controllable (e.g., the recovery process).

A Longitudinal Study of Time Perceptions and Adjustment After 9-11

Holman, Alison, PhD, University of California, Irvine; Silver, Roxane, PhD, University of California, Irvine; McIntosh, Daniel, PhD, University of Denver; Poulin, Michael, BA, University of California, Irvine; Gil-Rivas, Virginia, MA, University of California, Irvine

The relations between temporal orientation and ongoing psychological responses to the terrorist attacks of September 11, 2001, were examined in a national random sample of 1382 individuals. Data were collected at 2, 6, and 12 months post 9/11 using an anonymous Web-based survey methodology. Pre-9/11 mental and physical health data are available on most of these individuals. Past temporal orientation—focusing attention of prior life experiences—assessed 6 months after the attacks was associated with elevated levels of posttraumatic stress symptoms and global distress one-year after the attacks, even after controlling for pre-9/11 mental health, prior trauma, demographics, 9/11-related exposure and loss, and early levels of intrusive/ruminative symptoms. The degree of temporal disintegration that respondents reported having experienced immediately after the attacks—whereby the present becomes isolated from continuity of past and future time—was associated with high levels of past orientation and subsequent posttraumatic stress symptoms/distress. Temporal disintegration was highest among individuals reporting (a) prior mental health problems; (b) prior traumatic life events; and (c) high levels of exposure to, and loss from, the 9-11 attacks.

Heart Rate as an Early Predictor of PTSD: Integrating Research Results

Symposium (disaster) Adams Ballroom, 6th Floor

Zatzick, Douglas, MD, University of Washington School of Medicine; Pitman, Roger, MD, Mass General Hospital

Emergency departments provide initial care for injured survivors of individual and mass events. Early evaluation procedures would be enhanced if vital signs could be reliably used to predict PTSD. This symposium explores the disparate methodological approaches and results of investigations that have assessed the association between heart rate and PTSD.

Initial Subjective and Objective Physiological Arousal in PTSD

Eposito, Karin, MD, PhD, University of Miami School of Medicine/Jackson Memorial Hospital; Roatta, Victoria, University of Miami School of Medicine/Jackson Memorial Hospital; Bustamante, Victoria, University of Miami School of Medicine/Jackson Memorial Hospital; Mellman, Thomas, MD, Dartmouth Medical School

Increased psychological and physiological responses to traumatic reminders are key features of PTSD and may also characterize the initial reactions of those who develop PTSD. Recent studies have examined relationships among indices of physiological arousal in victims of trauma and subsequent PTSD symptoms, with conflicting results. In this report, we examine the relationships among vital signs recorded soon after trauma, subjective reports of physiological symptoms at the time of trauma, and the subsequent severity of PTSD symptoms in a population of injured accident victims. Vital signs were collected in the field and on arrival to the trauma center for 106 subjects. PTSD symptoms and initial reactions were assessed as soon as subjects were medically stable and PTSD was assessed six weeks later. Subjects were not intoxicated and were conscious and alert on arrival. Heart rate and blood pressure did not correlate with subsequent PTSD. Reports of "shortness of breath" and "rapid heart beat" correlated with respiratory rate but not with heart rate, blood pressure, or subsequent PTSD. Overall somatic reactions as well as "dizziness/feeling faint" and "sweating" did correlate with subsequent PTSD. These findings raise the possibility that vagally-mediated as well as sympathetically-mediated reactions may relate to development of PTSD.

Heart Rate Response Following Trauma and Subsequent PTSD

Shalev, Arieh, MD, Hadassah University Hospital; Pitman, Roger, MD, Harvard Medical School; Yehuda, Rachel, PhD, Mt. Sinai School of Medicine; Orr, Scott, PhD, Harvard Medical School; Banet, Yair, Hadassah and the Hebrew University Medical School; Tuval-Mashiach, Rivka, PhD, Department of Psychology, Bar Ilan University; Bargai, Neta, PhD, Department of Psychiatry, Hadassah University Hospital; Freedman, Sara, MSc, Department of Psychiatry, Hadassah University Hospital; Dalia, Brandes, MA, Department of Psychiatry, Hadassah University Hospital

Physiological arousal during traumatic events may trigger the neurobiological processes that lead to posttraumatic stress disorder. We prospectively examined the relationship between heart rate and blood pressure recorded immediately following traumatic event and subsequent development of PTSD in three separate studies. Two hundred and ten trauma survivors who presented at the emergency department of general hospital were followed up for six months. Heart rate and blood pressure were recorded on arrival at the emergency department one week, one month, and four to six months later. PTSD was predicted by higher heart rate in the emergency room in one study (n=84), but this finding was not replicated in subsequent studies. Physical injury and medical treatment received prior to arriving to the ER may reduce the predictive power of early physiological arousal. We discuss the implications of this finding for future studies of physiological predictors of PTSD.

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Heart Rate and PTSD Symptom Development: A Population-Based Study

Zatzick, Douglas, MD, University of Washington School of Medicine; Russo, Joan, PhD, University of Washington School of Medicine; Pitman, Roger, MD, Mass General Hospital; Roy-Byrne, Peter, MD, University of Washington School of Medicine

Purpose: Preliminary investigations in select samples of injured trauma survivors suggest an association between elevated emergency department (ED) heart rate and the subsequent development of PTSD. Method: Patients were 120 randomly selected male and female survivors of intentional and unintentional injuries ages 18 or older. Patients were evaluated in the ED of a level 1 trauma center, admitted to surgical inpatient units for treatment of their injuries, and enrolled in an early mental health intervention trial. Patients' vital signs were assessed upon initial presentation to the ED. PTSD symptoms were assessed 1, 3 and 6 months after the injury with the Posttraumatic Stress Disorders Checklist (PCL). Results: Initial mean heart rate in the ED was 93 bpm (SD = 19). In bivariate, and multivariate analyses that adjusted for relevant clinical, injury and demographic characteristics, there were no significant associations between initial ED heart rate and longitudinal PTSD symptom development. Conclusions: In a representative sample of injured patients, elevated heart rate was not a robust marker for later PTSD symptom development. Future investigations that explore biological parameters in real world trauma exposed populations may productively benefit from the incorporation of public health methodological approaches.

Emergency Department Vital Signs and Traumatic Stress Disorders

Veazey, Connie, PhD, Houston Center for Quality Care and Utilization Studies; Blanchard, Edward, PhD, Center for Stress and Anxiety Disorder, University at Albany; Hickling, Edward, PsyD, Center for Stress and Anxiety Disorder, University at Albany; Galovski, Tara, PhD, University of Missouri at St. Louis; Broderick, John, MD, Albany Medical College

Emergency department (ED) heart rate (HR) and blood pressure were examined in 76 motor vehicle accident (MVA) survivors. These participants were seeking treatment for Posttraumatic Stress Disorder (PTSD) approximately 13 months following their MVA. They were screened with the PTSD Checklist and included if they were currently symptomatic on this measure. Sixty-eight of these participants were then assessed with the Clinician Administered PTSD Scale (CAPS) for both current diagnostic status and retrospective diagnostic status for the month immediately post-MVA. Both current and retrospective PTSD participants had lower ED HR than those who were not diagnosed with PTSD at the two time points. There was only one significant difference on the BP measures; those currently diagnosed with PTSD had significantly lower DBP than those without PTSD. In a separate study, 33 participants transported to the ED after a MVA were assessed at two weeks for Acute Stress Disorder (ASD) and one month for PTSD. At the two weeks, there were no significant differences between participants diagnosed with ASD and those not diagnosed with ASD on ED HR or BP measures. Nineteen participants completed the one-month assessment, and there were no significant differences between those diagnosed with PTSD and those not diagnosed with PTSD on the measures.

Families Reported for Violence: Fragmentation or Integration?

Symposium (child) Wabash Room, 3rd Floor

Endorsed by the Child Trauma Special Interest Group

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

This symposium will examine the relational impact of violence in families. Using intergenerational and longitudinal data from the

Navy Family Study, three papers will examine family of origin and procreation relationships among a sample of 530 Navy families reported to authorities for either child sexual abuse, child physical abuse, or partner violence.

Child Adjustment and Relationships with Parents After Family Violence

Smith, Daniel, PhD, Medical University of South Carolina, National Crime Victims Center; Saunders, Benjamin, PhD, Medical University of South Carolina, National Crime Victims Center; Williams, Linda, PhD, Wellesley College; Hanson, Rochelle, PhD, Medical University of South Carolina, National Crime Victims Center

Children in families characterized by violence are at risk for a range of difficulties, including disrupted family relationships. These problematic relationships may in turn potentiate other problems, including psychopathology and delinquent behavior. This paper will describe the relationship patterns and relations among parent-child relationship quality and child adjustment using longitudinal data from the Navy Family Study (NFS). The NFS is a prospective examination of 530 families referred to naval authorities for intrafamilial sexual abuse, physical abuse or partner violence. Families were initially assessed within 6 weeks of the time of the report to authorities. Follow-up assessments were conducted 9 and 18 months post-report. Assessments consisted of interviews with the offending caregiver (OP), non-offending caregiver (NOP), and index child over 7 years of age (n=195), and paper-and-pencil questionnaires addressing individual and family functioning. Results will describe and compare the changes in family status over time (e.g., family disruptions and integrations) according to violence type (partner violence, sexual abuse, or physical abuse). Further, repeated measures analysis will be used to examine both NOP's and children's ratings of parent-child relationship quality (using the Parenting Practices Inventory) and child functioning as a function of family status (intact versus fragmented).

The Impact of Family of Origin on Family Functioning Post-Abuse

Williams, Linda, PhD, Wellesley Centers for Women; Saunders, Benjamin, PhD, Medical University of South Carolina

This paper will utilize data from a multi-site, longitudinal study of 530 families reported to the Navy's Family Advocacy Program (FAP) for family violence (including child physical abuse, child sexual abuse by a parent, and intimate partner violence.) In this study mothers and fathers (both offending and non-offending parents) and an index child were interviewed and completed psychological assessments. This paper will make use of intergenerational data about each adult's family of origin to examine the relationship between family of origin fragmentation and current family and individual functioning. Using adults' reports of dysfunction, violence and dissolution in their family of origin we will examine the relationship between family of origin functioning and current family functioning and adult social and psychological functioning following the report of child abuse or partner violence. Data from interviews with 485 mothers and 378 fathers will be analyzed. Measures include a structured in-person interview, the Family of Origin Scale, the Sexual Satisfaction scale of the DSFI, the SCL-90-R, and the Trauma Symptom Inventory. Implications for future research and interventions will be discussed.

Marital/Sexual Functioning After a Report of Family Violence

Saunders, Benjamin, PhD, Medical University of South Carolina; Williams, Linda, PhD, Wellesley College

Using longitudinal data from the Navy Family Study, this paper will examine the status of marital and sexual relationships among couples reported to authorities for family violence during the 9 to 12 months after the report. Relationship change over time, and potential explanatory factors for any relationship change, such as type of

violence reported, self-reported violence, relationship length, interventions received, and psychological functioning of the partners, will be tested. Participants include 453 nonoffending parents and 364 offending parents from 504 Navy families reported to authorities for child sexual abuse, child physical abuse, or partner violence. The participants include both partners in 313 married or cohabitating couples. Data were collected 2-4 weeks and 9-12 months after the report of family violence. Measures included a structured in-person interview, the Dyadic Adjustment Scale, Sexual Satisfaction scale of the DSFI, the SCL-90-R, and the Trauma Symptom Inventory. Preliminary data analysis indicated that at the initial assessment, both partners in 59% of the couples scored in the clinical range of the DAS, 34% of the couples had at least one partner in the clinical range, and only 7% had both partners in the nonclinical range. Implications for future research and clinical intervention will be discussed.

Older Adult Trauma Survivors

Symposium (clin res) Parlor H, 6th Floor

Featured Symposium

Cook, Joan, PhD, University of Pennsylvania and Philadelphia VA Medical Center; Schnurr, Paula, PhD, National Center for PTSD, White River Junction and Dartmouth Medical School

While research on frequency and impact of trauma in younger adults exists, there is little information about the prevalence, impact, and characteristics of traumatic exposure in older adults. This symposium will present empirical evidence from three studies (i.e., women residing in the community, VA primary care patients, emergency department patients).

Feasibility of Identifying Elder Abuse and Neglect in the Emergency Department

Cook, Joan, PhD, University of Pennsylvania & Philadelphia VA Medical Center; Datner, Elizabeth, MD, Philadelphia VA Medical Center; Shofer, Frances, PhD, Philadelphia VA Medical Center; Hornig, Mady, MD, Philadelphia VA Medical Center; Mechem, C. Crawford, MD, Philadelphia VA Medical Center; Shepherd, Suzanne, MD, Philadelphia VA Medical Center

The exact magnitude of elder abuse is not known. Empirical evidence on the prevalence and risk factors comes mainly from surveys of professionals or from highly selected samples (e.g., those reported to Adult Protective Services). This study evaluates the feasibility of assessing elder abuse and neglect in the emergency department (ED), and provides an initial estimate of its prevalence and correlates. 826 patients over the age of 60 were approached and only 426 were willing to participate. Of these 29 reported abuse or neglect by a caretaker. Information on type of abuse, abusers' characteristics, prior ED use, physical and financial independence, and current living situation will be presented. The ED is an important and often the only point of contact with abused elders in the community. However there are significant barriers to the use of routine screening to identify elders and get them into appropriate services such as elders' trust in confidentiality, and readiness to accept third-party interventions. Rather than relying on screening instruments, it may be more efficient to educate ED professionals in maintaining a high index of suspicion for signs of abuse and to prepare them to inquire in an effective and non-threatening manner.

PTSD Screening in Elderly Primary Care Veterans

Durai, U. Nalla, PhD, Chicago VA Health Care System, West Side Division; Cook, Joan, PhD, University of Pennsylvania, Philadelphia VA Medical Center; Coakley, Eugenie, MA, MPH, JSI Research and Training Institute; Llorente, Maria, MD, Miami VA Medical Center; Kirchner, JoAnn, MD, North Little Rock VA Medical Center; Oslin, David, MD, Philadelphia VA Medical Center; Krahn, Dean, MD, William S. Middleton Memorial Veterans Hospital; Olsen, Edwin, MD,

Miami VA Medical Center; Bartels, Stephen, MD, Dept. of Psychiatry, Dartmouth College

Purpose: To compare the socio-demographic characteristics and health status correlates of elderly veterans in primary care with and without PTSD symptoms. **Methods:** Cross-sectional analysis of screening data, collected as part of the PRISMe study, was conducted using univariate and bivariate methods on 14,662 (half are 75 years or older and 75% white) patients from five VA facilities. **Findings:** Approximately 30% of the sample (n=4, 407) had experienced a significantly traumatic event and 1,631 (11.1%) of them had ongoing PTSD symptoms. Patients with PTSD are more likely to exhibit the following characteristics (p<0.001): divorced/separated, tobacco/alcohol use, perceive their overall health status to be worse and fell more socially isolated. The level of emotional distress, measured by GHQ, was three times higher in patients with PTSD and only 16.3% were under current mental health care. Among patients subsequently enrolled in the PRISMe study, who met criteria for depression, anxiety and/or at risk alcohol use, comorbid PTSD was found to have a significant association with lower SF-36 mental health component scores. **Conclusion:** PTSD appears to be common in elderly veterans, but vastly underdiagnosed. Patients with PTSD exhibit increased risk of impairments in several psychosocial and health-related indices.

Older Women and Trauma: Investigation of Late Life Functioning

Walser, Robyn, PhD, National Center for PTSD/VA Palo Alto Health Care System; Cook, Joan, PhD, University of Pennsylvania, Philadelphia VA Medical Center; Ruzek, Josef, PhD, National Center for PTSD/VA Palo Alto Health Care System; Sheikh, Javaid, MD, VA Palo Alto Health Care System and Stanford University

Psychological and physical functioning of an individual may be powerfully impacted by exposure to trauma. Many younger women exposed to trauma have been found to have PTSD, high rates of lifetime depression, dysthymia, nonspecific distress, co-occurrence of PTSD and other axis I disorders. Often these women continue to have serious emotional, psychosocial, life satisfaction and other adjustment problems throughout their lifetime. The impact of trauma on older women, however, is not largely studied. The current study investigated the relationship between trauma history, symptoms of PTSD and general health. PTSD symptom severity, as measured by the TSC40 and PCL, was associated with poorer physical functioning in older women. Increased symptoms were more specifically related to decreases in general health, increased problems with pain, and less vitality. It may be that early trauma influences later health experiences. If this association holds, it will be important to develop information that can better inform clinical practice. Older women may need to be referred to counseling as a means to address trauma related issues. Becoming aware of trauma history and its impact can guide clinicians to provide appropriate interventions and services. Research findings and clinical implications will be presented.

A Grieving Urban Community: Child and Parent Co-Victims of Homicide

Workshop (child) Parlor B, 6th Floor

Ley, Susan, MSW, Wendt Center for Loss and Healing, Washington; Ward-Wimmer, Dottie, MA, Wendt Center for Loss and Healing; Handel, Stephanie, MSW, Wendt Center for Loss and Healing

There is a consistent theme of violence in our urban communities. Washington, D.C., ranks among the top five metropolitan cities in the U.S. for deaths related to homicide. Here, thousands of family members are left each year to grieve the homicide death of a loved one. Children, in particular, face unique challenges in their attempts to heal from the impact of violence and the stigma that usually accompanies homicide. This interactive workshop will share what child and parent co-victims of homicide have taught us. We will discuss techniques, themes, practical issues, process and proto-

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cols that have been utilized in developing a homicide specific support group model. Information about two complimentary programs, Camp-Forget-Me-Not and a City-Wide Homicide Memorial, will also be shared.

Identity and Meaning: Psychotherapy with Survivors of Torture

Workshop (culture) Parlor F, 6th Floor

Busi, Kimberly, MD, Bellevue/NYU Program for Survivors of Torture; Akinsulure-Smith, Adeyinka, PhD, Bellevue/NYU Program for Survivors of Torture; Nguyen, Leanh, PhD, Bellevue/NYU Program for Survivors of Torture; Smith, Hawthorne, PhD, Bellevue/NYU Program for Survivors of Torture; Aladjem, Asher, MD, Bellevue/NYU Program for Survivors of Torture

Psychiatrists and psychologists from the Bellevue/NYU Program for Survivors of Torture propose to lead a Workshop to help participants explore the themes of identity and meaning making encountered in our work with traumatized refugees and torture survivors. First, participants will be introduced to ways that multiple reference group identities of both the client and therapist impact on treatment. Emphasis will be placed on helping clinicians develop an understanding of these identities to empower clients to make meaning of self and experience. Next, clinicians will illustrate ways in which themes of identity and meaning have been manifested in their work with two specific groups of patients seen at our center: women survivors of war-related sexual violence and individuals persecuted for their sexual orientation. The aims here will be to explore the impact of trauma on the negotiation of gender and sexual orientation respectively. Three panel members, all senior clinicians with the Program will give 15 minute presentations on the above topics. The Chief Psychiatrist with the Program will lead a 30 minute discussion. Presenters will answer specific questions and solicit audience participation by raising issues for discussion.

Narrating Catastrophe: The 9/11 Oral History Narrative and Memory Project

Workshop (commun) Red Lacquer Room, 4th Floor

Cloitre, Marylene, PhD, Institute for Trauma and Stress, NYU Child Study Center; Clark, Mary Marshall, MA, Columbia University Oral History Research Office; Wiederhorn, Jessica, MA, Columbia University Oral History Research Office

Through this workshop, trauma specialists and oral historians will explore the common ground of life history narratives in developing individual and community resilience to severe traumatic stress. Mary Marshall Clark, director of the Columbia University Oral History Research Office, past president of the Oral History Association and founder of "The September 11, 2001, Oral History Narrative and Memory Project," through which over 500 people were interviewed following 9/11; Jessica Wiederhorn, associate director of the Oral History Research Office and past manager of academic affairs at Survivors of the Shoah Visual History Foundation; and Marylene Cloitre, Cathy and Stephen Graham Professor of Psychiatry, director of the Institute for Trauma and Stress, NYU Child Study Center and founder of the New York City Coalition for Effective Trauma Treatment after September 11, will lead an interactive workshop. Clark, Wiederhorn and Cloitre are working in partnership to develop multigenerational and cross-cultural oral history programs for youth and adults in New York City exposed to extreme and violent trauma and loss to "tell" their lives in new ways following the catastrophe of September 11, 2001. The presenters will speak about the relevance of oral history as a naturalistic form of storytelling to traditional therapies, with particular relevance to building resilience within communities and families.

What Your Advisor Never Told You: Your First Real Job

Workshop (train) PDR #4, 3rd Floor

Shipherd, Jillian, PhD, VA Boston Healthcare System, National Center for PTSD, Boston University; Kimerling, Rachel, PhD, National Center for PTSD; Melia, Kathleen, PhD, Concord Wellness Center; Roemer, Elizabeth, PhD, University of Massachusetts at Boston; Foy, David, PhD, Pepperdine University

There are many challenges to be faced with each transition an emerging psychologist must make in his or her development. During many of these stages, a plethora of advice and guidance is available about how to advance through the process smoothly. For many of us, advice and information was abundant on how to get into graduate school, and how to obtain and survive internship/post-doc years. However, another difficult transition can be the one from trainee to independent professional. This workshop is designed to provide an overview of the common challenges faced during your first "real" job in psychology. We will provide a perspective from several different environments including an academic setting, a clinical practice setting, a medical setting, and a government setting. Our goal is to discuss some of the following issues; Pros and cons of staying where you trained versus leaving, navigating politics, balancing time between personal and professional life, structuring your work hours to your best advantage (otherwise known as getting ahead/tenure), learning how to supervise and becoming a mentor. Within this context, we will highlight some of the common internal and external struggles that must be faced. Sponsored by the Gender and Trauma Special Interest Group.