TRAUMATIC stress points

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President's Column

Eve Carlson, PhD
President

Greetings! In late May, the ISTSS Board of Directors met in Mexico City for the mid-year board meeting. Some highlights of a very productive day and a half were:

- Extensive discussion of adding value to membership and establishment of a new position of Social Networking Administrator who will help ISTSS develop and make use of social networks to connect and inform members.

- Action on three recommendations of the Global Initiative Project Team, passing motions to establish a Global Meetings Committee, to establish two new types of membership, and to ask the Global Initiative Project Team to continue to explore alternative methods to build a global collaboration of organizations interested in trauma. The new membership types are for members of our affiliate organizations and for people who live in parts of the world that have no professional trauma organization. Both types will have no cost and include limited benefits.

Many board members also attended and presented at the 5th World Congress on Traumatic Stress in Mexico City on May 23-26, 2012. ISTSS co-sponsored the meeting, of which the theme was *Seeing What is in Front of Us: Addressing Trauma in Medical, Emergency and Mental Health Settings*. The program was excellent with simultaneous translation of presentations in Spanish into English and vice versa. Unfortunately, attendance was low, and there were several logistical challenges involved with planning a meeting in Mexico. We will certainly incorporate what we learned from the experience into the planning process for future meetings and collaborative conferences.

Congratulations to *Journal of Traumatic Stress* (*JTS*) editors and staff on an increase in the journal's impact factor in 2011 from 2.37 to 2.72 and 2011 ranking of 22/109 among clinical psychology journals and 32/117 among psychiatry journals. In a very competitive publication environment, *JTS* continues to increase its standing.

As the Travel Grants Committee considers this year's applications, please consider supporting the Travel Grants Fund (link). Each year, ISTSS awards travel grants to help support trauma specialists from developing countries that are engaged in cutting-edge research and important clinical work, but can't afford to attend the annual meeting. This year with our meeting theme focused on going "Beyond Borders", we want as many colleagues as possible to benefit from, and enrich, the large number of sessions about providing care for trauma survivors in low-resource settings. To help make this happen, click on the "Donate" button on the lower left side of the ISTSS home page at www.istss.org.

Lastly, we have added more online Expert Trainings. Members can purchase these videos and audio recordings of past conference programs (mostly PMIs) with or without CE credits at bargain prices. Put one on your iPod, mp3 player, or phone and expand your professional horizons while you commute or exercise! And help ISTSS market these high quality programs by forwarding the next marketing message you get to a colleague.

IN THIS ISSUE:

From Our Website: Do You Know?

ISTSS members can access the full versions of gold-standard interview and self-assessment measures of PTSD and other trauma-related issues. These include measures for adults and for children. Some measures are even available in multiple languages, including Spanish, German, and Chinese.

Visit the Assessing Trauma tab on the website to see what ISTSS has to offer.

ISTSS 2011 Lifetime Achievement Award: The Changing Field of Traumatic Stress Treatment

Mark Creamer, PhD
Clinical and Consulting Psychologist, Fairfield, Australia

ISTSS has been central to my professional identity for well over two decades, so it was a great honour to receive the ISTSS Lifetime Achievement Award in 2011. The award prompted me to think about how things have changed since I saw my first post-traumatic stress disorder (PTSD) patient in 1983.

The most obvious change has been the growth over the past 30 years in awareness and acceptance of the mental health effects of traumatic exposure. There was no mention of trauma or PTSD in my clinical training and it was not on the radar of most mental health professionals at that time. Prevailing opinion, where it did exist, was often pejorative. Terms like “compensation neurosis” and “inadequate personality” were still being used when mental health problems in the context of military or civilian trauma were discussed.

Thirty years later the situation is radically different. Most mental health professionals know at least something about PTSD and its treatment. Traumatic stress reactions have become almost commonplace in TV dramas, and when distressing events are reported on the news we routinely hear that “survivors are now receiving counseling”. Has the pendulum swung too far? I often think the answer may be yes and our key messages need to change accordingly.

In the 1980s, I spent much time trying to convince my colleagues and the broader community that these reactions were real and serious, deserving of research and clinical attention. In the last decade, I have spent much more time promoting human resilience and normal recovery, trying to dispel the myth that anyone who has an unpleasant experience requires the services of a “trauma counselor” (whatever that is). We do our patients a great disservice if we readily label every human response to disaster and trauma as pathological.

Underpinning this growth in awareness has been an exponential rise in the quantity and quality of research in the field. While by no means all research is good research, this general trend must be applauded. Over the last 30 years, we have developed a much more sophisticated understanding of the epidemiology of post-traumatic mental health. We know that most people will recover from the experience without developing significant mental health problems. We know that, among those who do develop post-traumatic mental health problems, PTSD is only one possible diagnosis – depression, substance abuse, and other anxiety disorders may be equally common. In the early 1980s it was difficult to discuss vulnerability factors for fear of “blaming the victim”. We have now moved beyond that to a good understanding of pre-, peri-, and post-trauma risk and protective factors that influence the development, maintenance, and recovery from disorder. Far from increasing stigma, this information is vital in improving our understanding of, and ability to respond to, these complex conditions.

All of us working in the field – whether clinician, researcher, or both – share the same overriding goal: to improve outcomes for people affected by trauma. The first randomized treatment trials did not appear until 1989; prior to that,

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most of us were left to draw on our theory and clinical training to guide our treatment, applied (hopefully) with a good measure of common sense. Now, a few decades later, we have a strong body of evidence to guide effective treatments, with internationally accepted guidelines to inform clinicians, consumers, and purchasers of mental health services following disaster and traumatic exposure. The strength of the evidence is now so strong that a failure to provide evidence-based treatment to someone with PTSD should be considered negligent.

So, we have come a long way in the last 30 years: what will the next thirty bring? My hope is that we will continue to refine our understanding of PTSD. It is not a single, homogenous condition. It is a label applied to a complex mix of clinical presentations. Only if we can better define these variations will we be able to tailor treatment to specific symptom profiles. A better understanding of the mechanisms underlying these conditions may help. With advancing technology, the role of genetics and other biological factors in the development and maintenance of disorder will continue to become clearer. I would urge caution, however, in embracing purely biological explanations. Perhaps more than any other field, ours is one in which interactions between biology and environment is fundamental.

We need to learn more about how best to disseminate effective treatments and how to ensure that clinical practice actually changes as a result. At the same time, we must improve our treatment effectiveness: current treatments are good compared to thirty years ago, but still around one third will not respond and many are left with residual vulnerability. Prevention and early intervention with the whole exposed population – not waiting until people develop serious disorders before we intervene – is perhaps the ultimate challenge. The research methodologies are complex and difficult, but it is incumbent upon us to rigorously explore the evidence for (or against) interventions such as psychological first aid (PFA) and skills for psychological recovery (SPR).

No doubt our field will undergo a myriad of other developments in the coming decades. I feel privileged, however, to have worked in the field through a period of such enormous growth and discovery. I genuinely believe that, working together internationally, we have been able to improve psychological health and quality of life for those whose lives have been devastated by trauma. We must now build on those strong foundations.

Mental Health Care for Urban, Low-Income, Diverse Communities

Bita Ghafoori, PhD
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Urban, low-income, minority adults have been found to have increased exposure to trauma, more psychosocial stressors, fewer coping skills, higher rates of PTSD, and fewer resources (Alim et al., 2008; Breslau et al., 1998; Gillispie et al., 2009; Switzer et al., 1999); however, these populations often do not access mental health care (Gavrilovic et al., 2005; Schacht et al., 2007). Some research indicates this group of trauma survivors may endorse a desire for mental health services, but are unlikely to receive PTSD focused treatment even after controlling for differences in socio-demographic status, physical and mental health status, and insurance (Davis, Ressler, Schwartz, Stephens, & Bradley, 2008; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999).

Possible individual barriers influenced by sociocultural factors that impede treatment seeking include the experience of daily crisis, lack of time, competing demands, and difficulty obtaining services (Davis et al., 2008; Hines-Martin, Malone, Kim, & Brown-Piper, 2003). Some studies suggest unfamiliarity with clinical services and ineligibility, lack of insurance, or limited insurance may serve as institutional barriers that may decrease treatment access among low-income Black and Hispanic trauma survivors (Davis et al., 2008; Norquist & Wells, 1991; Miranda, Azocar, Organista, Munoz, & Lieberman, 1996).

Stigma, including fear of family and community disapproval of treatment seeking as well as denying mental illness to avoid embarrassment, has also been found to serve as cultural barriers (Cooper-Patrick, Brown, & Palenchar, 1995; Davis et al., 2008; Gary, 2005) for Black trauma survivors specifically. Evidence from the existing studies underscores the importance of efforts to identify factors that influence mental health service use within urban, low-income, diverse groups in order to decrease health care disparities regarding obtaining trauma treatment.

Our recent study (Ghafoori et al., under review) used a mixed-methods approach to examine trauma exposure, mental health outcomes, treatment seeking, and barriers to care in low income, culturally diverse urban dwellers. Self-report questionnaires assessing traumatic events and mental health needs were administered to 181 adults who experienced a traumatic event. In subsequent semi-structured interviews with 27 individuals personal, cultural, and social factors associated with help-seeking were evaluated. Although need characteristics, specifically higher levels of PTSD and depression symptoms, were associated with mental health service use, most individuals in the study were not receiving mental health services for trauma-related distress.

Our results suggest that even for those receiving mental health care, some individuals were not being identified by their provider as needing trauma services and that the provider was not attributing the symptoms to trauma. Other historically identified sociopolitical factors such as fear related to mental health treatment, low mental health literacy, helplessness related to ongoing symptoms, and psychosocial issues (i.e. occupational and interpersonal difficulties) were identified as barriers to mental health treatment.

Our study results suggest therapeutic efforts for urban, low-income trauma survivors should focus on increasing knowledge about common reactions to trauma and trauma treatment, including assurances that past misuses of mental health practices with poor urban diverse communities will not be repeated. In addition, there should be increased screening of trauma by practitioners.

Implications for Practice and Research

Empirical knowledge of factors influencing mental health treatment seeking and barriers to care in urban, trauma-exposed, diverse groups is critical to inform ongoing efforts to adequately provide care. Often times, this group of trauma survivors is unaware of services that may be available, and education about traumatic stress reactions as well as treatment options may be beneficial. In addition, those serving these communities may not attribute the client's presentation to trauma and therefore not provide the most appropriate services.

The existing literature suggests many efficacious, evidence-based treatments for PTSD and other traumatic stress reactions; however, these treatments cannot be beneficial if they are not accessed. Moreover, future research needs

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to focus on dissemination of trauma-focused treatments to urban, low-income, diverse trauma survivors. This may require bringing efficacious treatments to "real-world" settings such as community mental health and health centers where the poor, disadvantaged, and vulnerable individuals are likely to seek services. In turn, these treatments should be evaluated for the efficaciousness with these communities.

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Trauma and World Literature – The Writing of Warriors: Viewing War From the Inside Out

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They say a picture is worth a thousand words – the words of warriors are different. For centuries, warriors have written in a way that has pulled us into the heart and horror of war. As illuminated by Jonathan Shay, Homer's epic poems, *The Iliad* and *The Odyssey* depict the brutality of men and war and the difficulty of homecoming in a way that has had timeless relevance for generations who have served. Ernest Hemingway experienced war firsthand and wrote dispatches from his many frontlines. Vietnam veteran and author, Tim O'Brien invites us to shoulder, *The Things They Carried* in Vietnam.

Building upon this tradition the United States National Endowment of the Arts has made a unique contribution to literature and to Americans who have served and their families. In a project called *Operation Homecoming: Iraq, Afghanistan, and the Home Front, in the Words of U.S. Troops and Their Families*, they reached out to the more than two million military members who have served in those wars and their loved ones and invited them to write about their personal experiences of the wars while the events were happening.

The response was overwhelming. The National Endowment of the Arts offered 50 writing workshops by esteemed literary figures on 25 bases in five countries, an aircraft carrier and a fleet ship in the Gulf. Six thousand troops participated – another 25,000 were sent the audio version.

The result was a total of 2,000 submissions and over 10,000 pages of diaries, poems, emails, letters, fiction and autobiographies from which a final compilation was chosen and edited as a book by Andrew Carroll. According to him, the goal of the final manuscript was to be as faithful as possible to the heart and soul of the writings "no matter how jarring or upsetting they be."

The resulting collection is emotionally riveting. In the words of warriors and their loved ones, it is a view of war from the inside out.

As an example, one of the literary pieces, the poem listed below, pulls you into an incident observed firsthand by 37-year-old Captain Robert W. Schaefer who jotted down his first draft only days after the launch of Operation Iraqi Freedom. (He would make only slight changes when he returned to the United States).

Yellow
or were they
blue? White, red
ribbon everywhere— Stay out.
But they were so small, plastic,
barely three
inches across. They didn't look
deadly. Two
soldiers wandered in curious.
One
said: "I wonder what would
happen if…"
and gingerly tapped one
with the toe of his boot
which then evaporated in a pink
frothy cloud,
a bubble gum pop, then cotton

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candy chunks
arcing lazily through the air
landing with little wet thumps
muffled by the sand. .
Then, he died—just like that
just that quickly.
One moment he was alive.
and curious
and the next, he was just a
scattering.
But the second was still alive
And so, to help him, without thinking
others ran into that minefield
pop
pop
We too now running, and I,
fastest, first, frozen
by the sight of so much crimson-
soaked clothing.
I didn't know where to start.
Covered with the blood of others,
later, I was mistaken as a casualty myself.
But I would not let them take my
Uniform
they would still live as long as
evidence
of them remained on my sleeves,
torn as they grasped for a few
extra moments.

The poem, like much of the writing, demands our emotional engagement in a very personal glimpse of war. The warrior's images capture us and steal our breath as they place us so close to sudden, inexplicable death and loss. This insider view can only come from being there, from experiencing war firsthand. This is the essential contribution of this volume.

In many ways it is fitting that this book is entitled *Operation Homecoming: Iraq, Afghanistan, and the Home Front, in the Words of U.S. Troops and Their Families*.

We understand that homecoming is always as much a psychological process as a physical one and we know that, for the warrior to really come home, he/she must tell his story in a way that makes it possible to remember, mourn, memorialize and go forward.

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ISTSS 28th Annual Meeting

"Beyond Boundaries: Innovations to Expand Service and Tailor Traumatic Stress Treatments"

REGISTER NOW!

Online registration is now available for the 28th Annual Meeting on November 1-3, 2012, at the JW Marriott Los Angeles at L.A. Live in Los Angeles, California, USA.
We hope to see you there!

Contribute to *StressPoints*

Trauma and World Literature Feature

Passages from literature can capture truths about trauma and its survivors.

ISTSS members are invited to share a favorite passage or quote from literature that might not be well known, but which offers insight about the psychological effects of trauma or path of healing.

Send submissions to Howard Lipke and Harold Kudler at HLipke@aol.com.

Members on the Move

ISTSS would like to extend sincere congratulations to long time ISTSS member **Yael Danieli, PhD,** for being chosen as the recipient of the Award for Lifetime Achievement in Trauma Psychology for 2012 by the American Psychological Association (APA) Division 56-Trauma Psychology.

The Awards Ceremony will be held as part of the Trauma Psychology Division Social Hour at the APA Annual Convention in Orlando, Florida on August 3, 2012.

Do you know of ISTSS members who have been recognized for significant achievements?

Please send announcements to Editor Patricia Kerig, p.kerig@utah.edu, for the *Members on the Move* feature.

Trauma and Maori LGBTQ (Takataapui) in New Zealand

Dr. Paul Reynolds
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As trauma-informed practice continues to grow in the mental health field, we will encounter many cultural nuances that require us to stretch and grow as practitioners. One such frontier for trauma-informed, culturally competent practice is trauma experienced by Maori lesbian, gay, bisexual, transgender, and questioning individuals (LGBTQ), or takataapui.

Maori are the Indigenous people of New Zealand and make up approximately 15 percent of the total population. As with other Indigenous peoples, Maori suffer disproportionately poorer health than non-Maori living in New Zealand. For takataapui, a term used to describe Maori LGBTQ, this may be exacerbated by the impacts of homophobia, social rejection, isolation and lack of access to culturally appropriate health services (Herewini & Sheridan, 1994).

For Maori and Indigenous peoples the world over, colonization has had an immense impact on Indigenous forms of sexual expression (Pihama et al., 2009). Takataapui (LGBTQ) whanau (family) members had a traditional role of caring for whanau, where they were seen as second mothers, teachers or educators, and providers of childcare for immediate and sometimes wider whanau. Traditionally they were also seen as caregivers of whangai (foster/adopted) children. Takataapui were part of the whanau, and it was acknowledged that they had a special role within it (Reynolds & Smith, 2012). With colonization, and especially with the introduction of Christianity, takataapui became seen as abnormal. What is concerning is that homophobia, social rejection and isolation can come from a takataapui person's own whanau (family), hapu (subtribe) and iwi (tribe).

Although there is little research specifically on Maori LGBTQ and the impacts of trauma (Pihama, 1998; Pihama et al, 2009; Reynolds & Aspin, 2006; Reynolds, 2010; Bodhran 2010), one study has highlighted the impacts of non-consensual sex among Maori men who have sex with men (MSM; Aspin, et al. 2009). The main findings from this study of Maori MSM who were raped or sexually violated (often without a condom), revealed the multiple impacts of trauma, including depression, anxiety, heart disease, compulsive eating, and social isolation. Additionally, the victims often kept silent around their victimization.

In treating Maori trauma survivors, it is important to recognize that the way Maori define, interpret, and respond to traumatic events is different from non-Maori. Culturally-competent mental health care of a Maori survivor may include a process of spiritual cleansing by using water from the sea, river or other waterway to purify and neutralize the effects of the violation, or receiving spiritual, physical and mental healing from a traditional healer, or simply by being embraced by a close whanau member, which can symbolically represent being enveloped and nurtured by all those whanau in the present and from the past. The trauma is not only seen as a trauma of the individual but a trauma that is carried by the survivor's whanau.

Maori LGBTQ have been gaining visibility and political clout in New Zealand over several decades. There are role models and heroes such as Carmen, Mama Tere and Georgina Beyer (the first openly transsexual Mayor and Minister of Parliament in the world), who have fought for the rights of takataapui. Each of these role models has come through their own personal trauma and identify as transsexual (Rupe& Martin, 1998; Armon, 2008; Beyer & Casey, 1999). In the book "Sexuality and the stories of Indigenous People" (Aspin & Hutchings, 2007), the personal journeys of takataapui identity and experiences are revealed. The consistent message coming through from all the stories was that being takataapui wasn't important in and of itself. What is important is being confident and strong in being Maori and LGBTQ and being accepted and supported by whanau and friends.

A new programme of research has started on Maori intergenerational trauma and healing, which brings together Maori and Indigenous researchers to explore the impacts of imprisonment, sexual violation and land alienation, as well as developing a healing/recovery pathway from trauma (TeAtawhai o teAo). This programme of research acknowledges that there are many sites of trauma, and within these sites are our takataapuiwhanau. This programme also acknowledges that we are a people severely impacted by trauma. This trauma is historical and intergenerational. We hurt deeply. We are trying to find our own ways to heal and recover.

Acknowledgement:
I would like to take this opportunity to acknowledge the Indigenous pioneers in the historical trauma field, which includes Dr. Maria Yellow Horse Brave Heart, Dr. Eduardo Duran, Dr. Bonnie Duran, Dr. Karina Walters and others. Nga mihi nui kia koutou katoa mo to mahi (Greetings, thanks and blessings to you all for your ground-breaking work).

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Aging, Trauma, and the Life Course

Anica Pless Kaiser, Jennifer Wachen, and Eve Davison
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As demographic patterns change across the globe, older people constitute a growing proportion of the population. Although many older adults enjoy well-being and satisfaction in later years, some experience mental health difficulties. A topic of particular significance to professionals working with or studying older adults is the understanding, assessment, and treatment of post-traumatic stress, which can re-emerge late in life.

There are a number of reasons why post-traumatic symptoms can increase with age. Role changes and functional losses may make coping with memories of earlier trauma more challenging. Such stressors include retirement, increased health problems, decreased sensory abilities, reduced income, loss of loved ones, decreased social support, and cognitive impairment (Cook, 2001). In early and mid-life, individuals can engage in avoidance-based coping strategies (such as drinking alcohol or over-committing oneself to work) to manage post-traumatic stress symptoms, but their strategies may be less available or effective as they get older. Such changes in behavior can have an impact on the (re)experience of symptoms. On the other hand, adaptation and resilience developed over a lifetime can provide a rich reservoir of coping resources. As these age-related factors can interact with psychiatric symptoms and have implications for research and clinical care, it is important for health care professionals to be well-informed regarding appropriate interventions. A relatively small, but growing, body of research has examined the prevalence of trauma exposure and the development and treatment of traumatic stress symptoms in older adults (age 65+).

Prevalence of Trauma Exposure and PTSD in Older Adults
Experiencing a traumatic event is a prerequisite for the development of post-traumatic stress symptoms and PTSD. In the general population, approximately 70-90 percent of adults aged 65 and older has been exposed to at least one potentially traumatic event during their lifetime (Norris, 1992). In contrast, another study found approximately 70 percent lifetime exposure to trauma among older men, and around 41 percent among older women. (Creamer & Parslow, 2008). The greater level of exposure for older men in this latter study may be attributable to combat experience.

Much of the research on PTSD in older adults has been conducted with veterans. For many older veterans, especially combat veterans, memories of wartime experiences can affect them long after their military service. Compared to the general population, older veterans have higher rates of both lifetime trauma exposure and PTSD symptomatology due to combat experience and warzone-related exposures. Among older male veterans, the prevalence of lifetime exposure to traumatic events is approximately 85percent. Estimates differ depending on the population being assessed; among psychiatric treatment-seeking older veterans, PTSD prevalence ranged from 37-80percent (Blake et al., 1990). There are several potential methodological reasons for this variability (Richardson, Frueh, & Acierno, 2010). For an excellent overview of PTSD prevalence and symptom presentation in older adults, please see Glück and Maercker's article in the May 2012 issue of *Traumatic StressPoints*.

PTSD and Comorbid Issues in Older Populations
Among older adults, comorbidity with PTSD is commonly observed with medical problems, psychiatric issues, and cognitive decline. Krause and colleagues (2004) found that greater lifetime trauma exposure is related to poorer self-rated health, more chronic health problems, and more functional difficulties. PTSD is associated with the occurrence of multiple medical problems such as arterial disorders, gastrointestinal complaints, dermatological problems, and musculoskeletal disorders (Kang, Bullman, & Taylor, 2006; Schnurr, Spiro, & Paris, 2000). Regarding psychiatric comorbidity, a diagnosis of PTSD is associated with higher rates of other mental health problems (Brady, Killeen, Brewerton, & Lucerini, 2000). In terms of cognitive problems, older adults with dementia may exhibit more PTSD symptoms. Conversely, PTSD may be a risk factor for dementia (Borson, 2010; Qureshi et al., 2010).

Trauma and PTSD among Older Women
Although some traumatic events, such as rape and domestic violence, are more frequently experienced by women than men, older women are often underrepresented in studies, making it difficult to assess the long-term consequences of interpersonal traumas. Higgins and Follette (2002) found that among a community sample of older women, 72 percent had experienced at least one type of interpersonal trauma (e.g., childhood physical or sexual

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abuse, rape), and that higher rates of interpersonal trauma were related to increased psychopathology. In comparison, approximately 44-55 percent of women of all ages experience lifetime interpersonal trauma (Iverson et al., under review; Tjaden & Thoennes, 1998). Middle-aged and older women (ages 45-70) are more likely than younger women to have experienced intimate partner violence for a longer time span and to remain in a violent relationship (Wilke & Vinton, 2005).

Late-Onset Stress Symptomatology

We and our colleagues at VA Boston are looking into a late-life process that may be a consequence of combat exposure earlier in life. This phenomenon, Late-Onset Stress Symptomatology (LOSS), refers to the development of increased thoughts and reminiscences about, and emotional responses to, one's wartime experiences. This process occurs in the context of losses associated with aging – such as retirement, loss of loved ones, and increased health problems – and can develop in veterans who have otherwise functioned well throughout their adult lives (Davison et al., 2006; King, King, Vickers, Davison, & Spiro, 2007). In contrast to PTSD, LOSS is associated less with clinically significant distress and is more related to older adults' search for meaning and growth in late life. Although LOSS has only been studied with combat veterans, these concepts may also apply to the general population of aging survivors of early-life trauma.

Considerations for Treatment of Older Adults

Interventions for PTSD that have the strongest evidence base are Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE). These therapies have not been extensively studied in older adults, and research on their efficacy with this population remains a ripe area for future research. Of note, there is a randomized controlled trial currently underway in VA examining the effectiveness of PE for older veterans with PTSD, with preliminary results demonstrating that exposure therapy with this group is both feasible and efficacious (Thorp, Stein, Jeste, Patterson, & Wetherell, 2012).

New Special Interest Group at ISTSS

A new SIG entitled, "Aging, Trauma, and the Life Course" will be holding its inaugural meeting at ISTSS in Los Angeles this November 2012. This SIG aims to appeal to researchers, clinicians, and policymakers from all disciplines who study trauma and aging or work with older trauma survivors (combat veterans or other survivors of war; Holocaust survivors; sexual trauma survivors; etc.), and who are interested in the unique ways in which trauma experienced at various points across the life course interacts with developmental factors to influence health and well-being. We hope to foster interdisciplinary collaboration and communication among all who are concerned with the impact that trauma has throughout the aging process, and to help disseminate knowledge regarding trauma and aging.

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Upcoming Events

August 2 – 5, 2012
American Psychological Association (APA)
2012 Annual Convention
Orlando, Florida
More Information

September 5–6, 2012
6th National Emergency Management Summit
Baltimore, Maryland
More Information

September 11–13, 2012
42nd Annual Meeting of the International Society for Psychoneuroendocrinology (ISPNE)
"Molecular and Hormonal Effects of Stress"
New York City, NY
More Information

September 28, 2012
State of the Art in Trauma and PTSD - From Research to Practice
Amsterdam, Netherlands
More Information

November 1 – 3, 2012
"Beyond Boundaries: Innovations to Expand Services and Tailor Traumatic Stress Treatments"
ISTSS 28th Annual Meeting
with Pre-Meeting Institutes on October 31
JW Marriott Los Angeles at L.A. LIVE
Los Angeles, California, USA

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