



President's Column

Eve Carlson, PhD
President

It is hard to believe that a year has already passed and this is my last president's column! In this last column, I will bring you up to date on the status of several efforts and other news.

- Recommendations of the Global Initiative Task Force, led by Ulrich Schnyder for the past two years, have given rise to a new committee. Jonathan Bisson and Miranda Olff will lead a Global Meetings Committee that will bring ISTSS efforts to promote advancement and exchange of knowledge about traumatic stress to a wider variety of locations around the world. They will plan one-day and regional meetings outside of the ISTSS Annual Meeting.
- Namik Kirlic has been appointed our Social Networking Administrator. He will lead efforts to build ISTSS presence on LinkedIn, Facebook, YouTube, and Twitter. Thanks go to Sarah Wilson who led the Social Networking Task Force and developed a plan for ISTSS to pursue.
- Election results are in and we have elected Nancy Kassam-Adams as ISTSS President-Elect, re-elected board members Diane Elmore, Julian Ford, Harold Kudler and Candice Monson, and elected Yoshiharu Kim and Miranda Olff as new members to the board. Congratulations to them all. We are continuing to elect members who infuse the board with perspectives from around the world with members who conduct research, clinical, and policy work in a wide range of settings.

In this last column, I want to thank the members of the Executive Committee (Marylene Cloitre, Karestan Koenan, Diane Elmore, Alain Brunet, and Dean Kilpatrick) for their hard work all year moving initiatives along and keeping ISTSS on track with its strategic plan. Leadership Council members (board members and work group chairs) too numerous to mention worked on a wide variety of tasks to move us forward. And—as always—our hard-working headquarters staff went above and beyond the call of duty to help us pursue our mission.

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Also, I want to especially thank Ulrich Schnyder and Marylene Cloitre for their past work to develop and elaborate our strategic plan and their efforts this year managing long-term projects begun during their years as president. Thanks also go to our Executive Director Rick Koepke, for helping ISTSS leaders become more strategic and for continually reminding us to stay strategic. When we operate strategically, we all row in the same direction, can undertake major projects that require many years to bring to fruition, and progress more rapidly toward our goals.

For the upcoming meeting in Los Angeles:

- Don't forget to download the full final program if you wish to have it during the meeting. The printed program will include descriptions of keynote and highlighted sessions, the meeting schedule and titles, presenters, and locations for each session.
- Follow @ISTSSnews on Twitter, like us on Facebook and connect with us on LinkedIn.

And if you can't make the meeting, keep an eye on our [Expert Trainings Web page](#) for video programs of select Master Clinician sessions and Pre-Meeting Institutes.



Film Review – *Striking a Chord: Music Can Heal Invisible Wounds*

Harold Kudler, MD
Duke University

Susan Cohn Rockefeller's documentary, *Striking a Chord: Music Can Heal Invisible Wounds*, follows the musical odyssey of singer/songwriter Nell Bryden and her band across Iraq with sharp images and trenchant insights that resonate on many levels.

Combat tours are long stretches of boredom punctuated by danger and adrenaline. Even if home is as accessible as Facebook in modern warfare, warriors are inexorably drawn into a bubble that contains their buddies, their mission and little else. This survival mode in a combat zone is fully adaptive *until* the war fighter tries to reconnect with anyone or anything outside that bubble. Readjustment home is difficult for returning warriors because they have been pulled so far outside their old lives that they have come to doubt who they were or what they may become. These interpersonal injuries are among the most profound (if invisible) wounds of war.

Like the sirens of the ancient Odyssey, Bryden's music draws powerfully on her listeners (perhaps a siren's song is always most potent with those far from home). Home, friends and family are the themes of Bryden's songs. I was particularly struck by her haunting, slow remix of the Sister Sledge classic, *We Are Family*, which seemed to help bridge the warriors' group need to connect intimately with their buddies *and* their need as individuals to reconnect with those at home.

Like another Homeric character, the Old Man of the Sea, Bryden has the uncanny ability to reshape herself in response to those around her. Her metamorphoses from glamorous singer to coquette to girl next door to daughter and even to mother allow her to empathically meet each warrior where he or she needs to be met. Each transformation reflects a connection (or, maybe better, a reconnection) to a pre-war life gone dormant.

As Rockefeller's documentary demonstrates, music's charms remain as potent as they were in the Golden Age. Music can reweave a torn tapestry of buddies, mission, memories, families, lovers and friends back into a seamless whole. As the Army's Battlemind training for homeward-bound soldiers has taught, the military skills and mindset that made them successful in combat should *not* be tried at home. Returning warriors often end up feeling like two different people trying to live one life. In many ways, this is the dark heart of Posttraumatic Stress Disorder: the inability to be sure whether you are living in the past or the present.

Music strikes a resonant chord capable of aligning and harmonizing the dissonant thoughts, feelings, and experiences of a war fighter's life. And, even if this rapprochement only lasts as long as a concert or even a single song, music provides a vital reminder that there still *is* a connection to be made. This can literally save lives and begin the work of rebuilding them. Thanks to *Striking a Chord*, those of us on the home front have a chance to understand the enduring power of music and its significance for those fighting our wars a great deal better.



From Our Website: Do You Know?



The website provides access to over 20 videos on topics such as PTSD, refugee trauma, child traumatic stress, domestic violence, and combat trauma. Most of these videos are free and can be streamed right to your computer.

The videos are intended for a number of audiences, including mental health care providers, the general public and consumers.

Start browsing [our selection of videos](#) now.



Trauma and World Literature: Alice Munro Short Stories



Howard Lipke
Rosalind Franklin University of Health Science

I would not be the first to point out that many of Alice Munro's short stories have the depth of novels. In her story "Dimensions," Munro, who knows what it is to lose a child, shows the extreme version of such a catastrophe. Her hero, Doree, has suffered through the murder of her children by her, until then, psychologically abusive husband. Munro writes profoundly about Doree's response. Among the many things she elucidated, it is the relationship between Doree and her therapist (Mrs. Sand) that will be addressed here. While her therapist is portrayed as competent and caring, Doree terminates therapy by simply not making a next appointment.

Through the course of the story we see in brief strokes how the therapeutic relationship developed, how it was and was not useful to Doree, and its effects, even after termination. While psychotherapists might debate the ultimate value of the kind of comfort Doree eventually begins to find, Munro offers an interesting exploration of one kind of spirituality.

In the following passage Doree has begun to visit her incarcerated husband, and is reacting to a letter from him:

"Doree wondered what Mrs. Sand would say or think if she read this letter. Mrs. Sand would be careful, of course. She would be careful not to pass an outright verdict of craziness but she would carefully, kindly steer Doree around in that direction.

Or you might say she wouldn't steer—she would just pull the confusion away so that Doree would have to face what would seem to have been her own conclusion all along. She would have to put the whole dangerous nonsense—this was Mrs. Sand speaking—out of her mind.

This was why Doree was not going anywhere near her."

This and other passages on this theme, and on the psychology of perpetration, as well as the depth of evocation of the effects of trauma make this the first work of fiction I offer to trainees.



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.

Expanding the Definition of Traumatic Stress in Sexual Minority Populations

Edward J. Alessi, PhD, LCSW

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Rejection by family, anti-gay bullying and harassment, and condemnation from religious groups are just some examples of the stressors that lesbian, gay, and bisexual (LGB) individuals frequently encounter. Often involving prejudice and discrimination, these events are considered a consequence of minority stress, which is defined as “a state intervening between the sequential antecedent stressors of culturally sanctioned, categorically ascribed inferior status, social prejudice and discrimination, the impact of these environmental forces on psychological well-being, and consequent readjustment or adaptation” (Brooks, 1981, p. 107).

Meyer (2003) applied the minority stress concept to explain the connection between social stress and psychiatric disorders among LGB individuals. He suggested that, similar to other minority groups, LGB individuals encounter acute and chronic stressors due to heterosexist and homophobic social conditions. In turn, this excess exposure to stress leads to higher prevalence of psychiatric disorders among LGB individuals, as compared to heterosexual individuals (Meyer, 2003).

Population-based studies support minority stress theory-based hypotheses—studies show that LGB individuals have higher prevalence of mood, anxiety (including PTSD), and substance abuse disorders than heterosexual individuals (Cochran & Mays, 2000; Cochran, Sullivan, & Mays, 2003; Gilman et al., 2001; Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010; Sandfort, de Graaf, Bijl, & Schnabel, 2001). More recently, Roberts et al. (2012) found that sexual minority youth were at greater risk for PTSD than heterosexual youth, with child abuse disparities accounting for 33 to 50 percent of PTSD disparities. The higher prevalence of PTSD among sexual minority adults and youths suggests that clinicians should assess whether their LGB clients have experienced traumatic events involving prejudice, including childhood abuse, and follow-up with PTSD assessment questions when appropriate.

Clinicians should also consider that exposure to non-life-threatening prejudice events may precipitate a PTSD-like disorder among LGB individuals. Scholars have argued that experiencing non-life-threatening prejudice events can also be traumatic, since they can be experienced as a threat to one's safety and psychological well-being (Bryant-Davis & Ocampo, 2005; Helms, Nicolas, & Green, 2010; Loo et al., 2001; Waller, 2003). In fact, there is some evidence that non-

Criterion A1 prejudice events, such as verbal harassment (D'Augelli, Grossman, & Starks, 2006) and being treated unfairly by a friend or boss or being rejected by a family member or friend (Szymanski & Balsam, 2011), are associated with PTSD symptoms among LGB individuals.

Furthermore, Alessi, Martin, Gyamerah, and Meyer (in press) found that exposure to non-Criterion A1 (sexual orientation or racial) prejudice events, such as non-life-threatening physical assault, non-life-threatening childhood abuse, harassment, and termination from employment, was associated with a PTSD-like disorder among eight LGB participants. More studies should examine whether non-life-threatening prejudice events are associated with PTSD, as these findings are meant to lay the groundwork for future research in this area.

In the meantime, clinicians should not overlook the possibility that individuals may suffer from a PTSD-like disorder following exposure to non-life-threatening events, and thus should assess for PTSD symptoms, regardless of whether a prejudice event is life-threatening or non-life-threatening. Because individuals might not be able to connect their symptoms to a specific event, clinicians should help clients understand the relationship between PTSD symptomatology, event exposure, and minority stress.

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Using Heart Rate to Quantify Exposure in Exposure-Based Treatment of PTSD

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Emotional Processing Theory (EPT)¹ emerged from Lang and colleagues' Bioinformational Theory of Emotion (BTE)² as a way of conceptualizing pathological fear². The theory defines the pathological fear structure as being comprised of three parts: (1) one's perception of an innocuous, but trauma-associated stimulus, (2) the cued physiological response to that stimulus, and (3) the associated meaning of the stimulus and the situation in which it is confronted as threatening and worthy of some action².

Deliberate or unintentional avoidance of trauma-associated stimuli reinforce one's distorted perceptions that the world is wholly unsafe, the self incompetent, and others untrustworthy,¹ as alternative information about the relative safety of those stimuli are not learned. According to Foa and colleagues³, modifying the pathological fear structure requires one to "...confront safe but feared thoughts, sensations, situations, and activities... to activate the fear structure and at the same time provide corrective information about the nonthreat value of the stimuli, responses, and meaning elements evoked during the exercise" (p. 8).

Exposure-based treatment models employ strategies thought to activate the fear structure, which is theorized to play a key role in incorporating *new* information into the trauma memory. For example, in Prolonged Exposure (PE) therapy patients engage in imaginal exposure during which they repeatedly narrate the traumatic event in first person and present tense, then process that experience with the therapist⁴.

In Trauma-focused Cognitive Behavioral therapy (TF-CBT), children work with a therapist to develop a trauma narrative, a written account of the event that is read aloud and revised several times as the child is encouraged to give a more detailed account of the event, provide a richer emotional description, and challenge distorted cognitions or maladaptive beliefs about the event and how it has affected the child⁵. In both PE and TF-CBT, patients also commit to tasks completed outside of session during which they *expose* themselves to innocuous situations that are associated with the trauma and that cause them distress.

One function of therapeutic exposure is to facilitate habituation – the attenuation of physiological and emotional responses to the trauma-associated stimuli – whereby patients learn that they can think and talk about the traumatic experience and yet feel safe. Another function is to facilitate patients' reorganization and reconceptualization of past events. Through cognitive-emotional processing or narrative development the therapist subtly challenges distorted or unhealthy cognitions and encourages the patient to consider alternative possibilities. One can see how altering the *meaning* behind the fear stimuli and attenuating physiological and emotional responses to associated stimuli starts to override the fear structure.

Subjective ratings of arousal or distress are obtained during exposure therapy, and clinicians use these to gauge the degree to which a patient's fear structure is activated and habituation is occurring. Several studies have demonstrated that higher ratings (i.e., greater activation) on the subjective units of distress scale (SUDS) during early exposure sessions predict better outcome in adult patients⁶⁻⁸. However, other studies have failed to find this relationship⁹. The same studies have also reported that PTSD symptom severity positively correlates with initial SUDS ratings, and that between-session diminution of SUDS ratings predicts more favorable outcomes^{6,7,9}. These findings are consistent with the mechanistic proposal that trauma-related symptomatology influences the degree of activation of one's fear structure and that fully activating the fear structure during exposure, relative to an individual's ceiling, drives habituation between sessions and a reduction in symptoms.

Arguably, a more objective way of measuring fear activation is by examining measures of autonomic activity, which may add incremental validity to self-report ratings. A large literature exists linking autonomic activity with PTSD symptoms in adults,¹⁰ and a few studies examine this relationship in children¹¹. Further, a number of studies have reported that increases in autonomic responsiveness during early exposure sessions predict more favorable treatment outcomes in adults with specific phobia and agoraphobia^{12,13}, claustrophobia¹⁴, and driving phobia¹⁵; however, studies of autonomic activation during exposure treatment in PTSD patients are lacking.

Using Heart Rate to Quantify Exposure continued from page 6

A collaboration of colleagues from the University of Delaware and the State of Delaware Department of Services for Children, Youth, and Their Families is examining changes in autonomic activity (i.e., change from a 5-minute baseline) during therapy sessions in children and adolescents receiving TF-CBT as part of a larger effectiveness study¹⁶.

Preliminary analyses of 22 patients are consistent with the proposed mechanism described above. A greater in-session increase in heart rate relative to baseline early in treatment, during skills development, is associated with pre-treatment PTSD symptom severity, $r = 0.66$, $p = .004$. Mean heart rate is greater during skills development (*Mean* = 90.03 ± 11.46 ; sessions 1 - 5) than during trauma narrative development (*Mean* = 87.98 ± 8.99 ; sessions 6 - 10), but not significantly so ($p > 0.1$).

This is consistent with, but inconclusive of, habituation between the skills phase and the exposure phase of treatment. Finally, the greater the increase in heart rate, relative to baseline, during trauma narrative development, controlling for heart rate during skills development, significantly predicts greater pre- to post-treatment reduction in PTSD symptom severity on the UCLA PTSD Reaction Index in a linear regression analysis, $B = 0.57$, $SE = 0.24$, $t = 2.4$, $p = .035$.¹⁷

Can psychophysiological measures help to determine when the fear structure is *sufficiently activated*? Is there a universal threshold by which to define sufficient activation, or do thresholds vary due to individual differences, including PTSD symptom severity? Answers to these questions may have important clinical implications. Heart rate is a relatively non-invasive, inexpensive, robust, and easy measure to obtain. The aforementioned study used an ambulatory device approximately the size of a digital music player. Three electrodes are attached with adhesive pads: one on the child's left and right sides, just below the breastbone, and one just below the collarbone. Most children are able to place the side electrodes on themselves and parents and technicians assist as necessary. The entire setup lasts approximately 2-3 minutes.

If clinicians could use heart rate to determine when a patient has been sufficiently exposed (i.e., optimal levels of fear structure activation) then: (a) the number of necessary sessions for effective treatment can be personalized, making treatment more time and cost efficient; (b) exposure strategies can be personalized based on how effective they are in facilitating fear structure activation (e.g., narrative development vs. imaginal exposure); and (c) patients who do not appear to be *activated* as indicated by self-report or observation may paradoxically be experiencing high physiological activation.

To elaborate more on the latter, let me briefly mention one of the patients in the aforementioned sample who was the subject of an unpublished case study. The patient was a 13-year-old boy referred to us due to severe physical abuse at the hands of his biological father in which he was repeatedly beaten and tortured. In therapy, the patient presented as highly avoidant and reserved. He responded to therapist's prompts with silence or with one- to two-word answers. He did not appear to be emotionally engaged. The therapist, however, pressed on and was persistent in discussing the trauma material, often transforming the boy's short responses into complete sentences. Paradoxically, while, the patient did not outwardly show arousal, he did show an increase in heart rate during the exposure phase that was comparable to other patients in the sample with more self-reported and observed emotional activation.

This observation and others like this seem to suggest that some traumatized children who present as highly avoidant, blunted, or non-engaged during exposure therapy may actually be experiencing physiological arousal and engaging in cognitive-emotional processing of trauma material internally rather than outwardly. If this were the case, then physiological assessment would indeed be instrumental in treating this subtype of patients.

Acknowledgement

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ISTSS 28th Annual Meeting

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We hope to see you there!

Join the World Health Organization's Global Clinical Practice Network

The World Health Organization's (WHO) Department of Mental Health and Substance Abuse is forming a global network of mental health professionals to help inform the development of the classification of Mental and Behavioural Disorders in next version of the International Classification of Diseases (ICD-11), currently planned for publication in 2015.

You are invited to register for the new Global Clinical Practice Network (GCPN). As a part of this international group of mental health professionals, you will be asked provide information and feedback to us based on your clinical expertise, experience, and knowledge as we develop the new classification of mental and behavioural disorders.

The Global Clinical Practice Network (GCPN) will be of vital importance to ensuring that the new classification is clinically useful, easy to use and accurate. One of the first GCPN field studies will be in the area of Disorders Specifically Associated with Stress, so WHO is particularly interested in enrolling professionals who are experienced in this area as a part of the GCPN.

As a participant in the GCPN, you may be asked to review materials, offer feedback about ideas or concepts that we are developing, or participate in specific types of field studies. The information you provide will inform WHO's decisions about the content and structure of the new classification system, as well as how that information will be presented to different users. The survey that WHO sends to you will be based on your own professional interests and areas of expertise.

Once registered in the GCPN, you will receive survey requests no more than once a month, and each survey will take approximately 20 minutes to complete. Your participation will be completely voluntary, and your responses will be kept confidential, secure, and will not be released to anyone else. WHO will never ask you to provide information that could be used to identify any of your patients. Data will be analyzed in aggregate form and used exclusively for the purpose of ICD revision. The first studies are expected to begin within the coming months.

To register for WHO Global Clinical Practice Network, please enter one of the following links in your Internet browser:

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Arabic:

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If you have any questions about the Global Clinical Practice Network or about your participation, please contact Spencer Evans at evanss@who.int.

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June 6 – 9, 2013

ESTSS Conference
Trauma and its clinical pathways: PTSD and beyond
Bologna, Italy

June 13 – 15, 2013

Canadian Psychological Association
74th Annual Convention (Congrès annuel)
Quebec City, Quebec, Canada

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