



International Society for Traumatic Stress Studies | [www.istss.org](http://www.istss.org) | [istss@istss.org](mailto:istss@istss.org) | +1-847-480-9028



## President's Column

*Eve Carlson, PhD*  
*President*

What's new with ISTSS? Well you can now get the absolute latest news by following our Twitter feed! Yes, even though many of us still remember data punch cards, some of our more social media savvy members will help pull us into the digital age at our annual meeting in L.A. in November. Follow us by going to Twitter and searching @ISTSSnews. We will be using the hashtag #ISTSS for this year's meeting. So download the Twitter app to whatever device you'll be carting around, and follow the meeting action moment by moment.

A couple of additional considerations in your digital planning for this year's meeting are:

1. We will have an Internet Café available, but will not have Wi-Fi in the meeting rooms. The \$19,000 price tag for Wi-Fi seemed too steep, and we didn't want to raise registration fees any higher. So if you've got a data plan and plan to surf during the meeting, up your data allotment for the month.
2. We will not have an e-book this year because there was very little use of it last year. A downloadable PDF of the full program (including all the abstracts) will be available and attendees will get a printed program that includes the schedule with details on keynote addresses, master clinicians, master methodologists, and titles and presenters for all presentations and posters. The online itinerary builder will also be available for attendees.

If you haven't already checked it out, our home page [www.istss.org](http://www.istss.org) is showing highlights of the upcoming annual meeting. You can click on those for details. In the middle of the page under "2012 Annual Meeting," you can also see questions that our keynote and master speakers will be addressing in their talks. PMIs are being highlighted on the right-hand side. Want to see the entire program before you register? You can [download it here](#). What you see is what you'll get!

There are a few new elements in the program this year. As

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part of our ever-expanding global awareness, the region that is the focus on each presentation is noted in the listings. The schedule in the program uses shading this year to help us spot the workshops, panels, and master session listings that are small and easy to miss. Program Co-Chairs Debra Kaysen and Wietse Tol and I are eager to see what happens with the new roundtable format. We hope those sessions provide a forum for discussion of new approaches and knotty problems. If you come to the meeting, please attend at least one and let next year's program committee know your opinion via the meeting evaluation.

Additional meetings that are planned around the L.A. meeting include:

- Global Collaboration Meeting: Representatives of traumatic stress societies from around the world will meet to identify objectives and begin planning to address trauma on a global level.
- Leadership Council Meeting: The chairs of all ISTSS work groups will meet with the board of directors to review our strategic plan and make specific plans for each group for next year.

So what are you waiting for? Get yourself [registered](#) and see you in L.A.!



## From Our Website: Do You Know?



You can view the ISTSS Treatment Guidelines for PTSD on the [Treating Trauma](#) section of the website.

Find out what the guidelines have to say about CBT for adults and children or how best to deal with comorbid conditions.

You can also purchase your own copy of the complete guidelines by [clicking here](#).

## EMDR Humanitarian Assistance Programs: Building Sustainable Mental Health Resources Worldwide

**Francine Shapiro, PhD**

*Senior Research Fellow Emeritus, Mental Research Institute  
2011 Sarah Haley Memorial Award for Clinical Excellence Recipient*



EMDR Humanitarian Assistance Programs (HAP) began in 1995 as a response to the Oklahoma City bombing. An FBI agent who had previously received EMDR therapy called requesting help, stating that the local mental health professionals were overwhelmed by the task. After a needs assessment, approximately 100 volunteer clinicians trained in EMDR therapy were rotated in to provide pro bono treatment for the bombing victims and front-line responders. A program evaluation indicated that over 80 percent achieved beneficial treatment effects within three sessions, and, in the same year, a study using a delayed treatment control group also showed positive results (Wilson, Becker & Tinker, 1995). Subsequently, free trainings in EMDR therapy were offered and provided to 290 clinicians in collaboration with local agencies. The feedback was so positive that a 501(c)3 organization was soon established.

Since that time, HAP has coordinated projects throughout the U.S. and internationally in more than 30 countries. The goals of the organization include (a) educating the public about the effects of trauma, (b) providing support for professionals working with underserved populations, and (c) treating victims post-disaster and in war zones. HAP projects train those serving afflicted populations in developing nations, such as clinicians working with AIDS orphans in Addis Ababa. Projects have been conducted with clinicians on both sides of ethnopolitical and religious conflicts, such as Bosnia/Croatia, Northern Ireland and parts of the Middle East. The overall goal is to alleviate the immediate suffering, while simultaneously preventing the intergenerational transfer of both the pain and violence that are often the legacies of traumatization.

Within the U.S., HAP collaborates with inner-city nonprofit agencies to provide trauma education workshops and clinical trainings. It also coordinates a Trauma Recovery Network of regional associations where volunteer clinicians become proficient at emergency response methods, instruct local emergency managers on the nature of trauma and its treatment, and make themselves available to provide pro bono services in the event of a disaster in their home communities or elsewhere. HAP volunteers have both trained and supported local clinicians by providing direct services after manmade and natural disasters, such as 9/11 and Hurricane Katrina. An assessment of the impact of direct volunteer services provided after the terrorist attacks in New York City demonstrated the effectiveness of both immediate and delayed EMDR treatment (Silver et al., 2005).

In 2002, HAP reorganized and revamped services to more effectively deploy its cadre of volunteers for international capacity building. While direct treatment services are still provided upon request, such as after the recent earthquakes in Haiti, the current primary focus of HAP is to empower communities in collaboration with local agencies through training programs for clinicians, and by providing trauma education and stabilization technique workshops for selected lay populations such as teachers, nurses, and monks. There are several advantages to this model. First, teaching mental health professionals EMDR therapy provides them with a means of treating the

*EMDR Humanitarian Assistance Programs* continued from page 2

emotional effects of trauma in an efficient and effective manner. Second, as familiar and trusted members of the affected community rather than outsiders, these professionals have an immediate rapport with the victims that further increases their outreach. Third, they are prepared to respond when disaster strikes. For instance, clinicians trained by HAP at the request of the Turkish Psychological Association (Istanbul Branch) treated the victims of the Marmara earthquake in tent cities, and demonstrated that 92.7% of a representative sample of 1,500 of those with PTSD lost the diagnosis after an average of five 90-minute EMDR sessions, with a reduction in symptoms in the remaining participants (Konuk et al., 2006). A permanent trauma center was established, and since that time Turkish therapists have launched humanitarian projects to treat victims of floods and numerous terrorist attacks.

EMDR therapy does not include homework, which makes it amenable to consecutive-day treatment. It is also unnecessary to describe the memory in detail, which facilitates effective treatment in cultures that are reticent about personal disclosure, and appears to decrease vicarious traumatization in the providers. This makes it highly useful for field teams in post-disaster areas. Subsequently, HAP training participants in Latin America, Asia, and Africa created clinical professional associations to ensure that evidence-based treatment remains self-sustaining in their homelands. They also provide services to others in need. For instance, 100 Indian clinicians trained by HAP provided treatment to over 16,000 survivors of the Gujarat earthquake in 2001. In 2004, these clinicians subsequently treated 5,000 tsunami victims in South Asia.

Training local clinicians helps to circumvent the problems caused by delayed international responses to traumatic events and builds sustainable resources in communities often plagued by natural disasters and/or the effects of violent conflict. The positive outcomes of post-disaster interventions as the result of HAP programs have been published in several peer-reviewed articles. For instance, during a HAP project following a hurricane in Mexico, an EMDR group treatment protocol was developed (Jarero et al., 1999) that has now been used worldwide with great success. Rapid treatment effects have been demonstrated after 1-4 sessions in interventions throughout Latin America, in Italy, and in the Palestinian territories (e.g. Adruziz et al., 2009; Fernandez, Gallinari, & Lorenzetti, 2004; Jarero et al., 2006, 2010; Zaghrou-Hodali et al., 2008).

HAP and its affiliated European EMDR humanitarian assistance programs invite collaboration with interested organizations and researchers to help ensure emergency preparedness, disaster response and effective trauma treatment worldwide. Visit our website at <http://www.emdrhap.org>.

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## The Trauma of Institutional Betrayal

Carly P. Smith and Pam Birrell  
*University of Oregon*

In the past years, and again recently, egregious cases of leaders of institutions, such as churches, the military, and schools, betraying abuse victims, have come to light. Victims in these cases experience not only betrayal by the perpetrator, but by those leaders who allowed a culture to exist that made abuse more likely and failed to respond effectively when abuse was detected. Here, we discuss some new work on betrayal, its effects on abuse survivors, and how we might change.

Betrayal Trauma Theory (Freyd 1994, 1996; Freyd, DePrince, & Gleaves, 2007) posits that the need to maintain attachment relationships often accounts for the unique post-traumatic sequelae of interpersonal abuse. The clearest case of this is betrayal blindness — the state of being consciously unaware of personal abuse committed by a trusted or depended upon other (Freyd, 1994; 1997). This blindness may be as extreme as a complete lack of memory of episodes of abuse or more minor such as the tendency to overlook indications of infidelity (Gobin & Freyd, 2009). While it is typically maladaptive to remain unaware of these transgressions as it increases the likelihood they will reoccur, the need to maintain a necessary relationship takes precedence (Gobin & Freyd, 2009; Goldsmith, Barlow & Freyd, 2004).

The research in this area has largely focused on emotional, physical, and sexual abuse committed by one individual against another individual (e.g., incest within a parent-child relationship, domestic violence between romantic partners, sexual harassment or assault between an authority figure and subordinate). Institutional involvement in this type of abuse is often indirect and occurs around individually perpetrated violence (e.g., the recent convictions of sexual abuse occurring at Penn State University, military sexual assault or clergy sexual abuse).

Larger institutions often elicit similar trust and dependency from their members as is found in interpersonal relationships (Cardador, Dane & Pratt, 2011; Somers, 2010; Tremblay, 2010). Often, as with trusted interpersonal relationships, these institutional environments are expected to be safe (Platt, Barton & Freyd, 2009; Tremblay, 2010) and indeed, may be quite literally depended upon for survival as in the military.

We posit that these more severe outcomes associated with trauma experienced in institutional settings can be explained by Betrayal Trauma Theory. For example, Betrayal Trauma Theory would predict that sexual assault occurring in a context where one's safety is dependent upon an institution (e.g., the military) would be associated with more difficulties as one continues to try and function in that environment (e.g., continuing to serve in the military). In this way, we predict that sexual assault occurring in a context where an important institution acts in a way that betrays its member's trust will be especially damaging — what we call 'Institutional Betrayal'.

Recent research in our lab has found parallels between betrayals experienced at an individual level with that experienced as institutional betrayal. Smith and Freyd (in press) examined the outcomes associated with institutional betrayal in a sample of college women ( $N = 345$ , 79% Caucasian; Mean age = 19.69,  $SD = 2.55$ ). The main focus of this study was whether institutional failure to prevent sexual assault or respond supportively when it occurs exacerbated post-traumatic symptomology. A new measure, the Institutional Betrayal Questionnaire (IBQ), created by Smith and Freyd for this study, was used to assess institutional betrayal surrounding unwanted sexual experiences (Smith & Freyd, 2011). The questionnaire defines an institution as, "... large systems such as a university, the military, the Greek System (i.e., the Fraternity/Sorority System as a whole), or organized religion. Additionally, this can refer to parts of these systems such as a campus dormitory, a military unit, a specific fraternity or sorority, or a particular church." Almost half (47%) of the women reported at least one coercive sexual experience and another 21% reported no coercion but at least one unwanted sexual experience.

Institutional betrayal (e.g., creating an environment where these experiences seemed more likely, making it difficult to report these experiences, etc.) was reported across different unwanted sexual experiences (47% and 45% of women reporting coercion and no coercion, respectively). Those women who reported institutional betrayal surrounding their unwanted sexual experience reported increased levels of anxiety, trauma-specific sexual symptoms, dissociation and

*The Trauma of Institutional Betrayal* continued from page 4

problematic sexual functioning as compared to women who had similar experiences but did not report institutional betrayal. These results suggest that institutions have the power to cause additional harm to assault survivors. Understanding the role of institutional betrayal is essential to understanding survivors' experiences, prevent abuse within organizations, and to respond effectively when abuse occurs.

This phenomenon is discussed further in an upcoming book, *Betrayal* (Freyd and Birrell, in press), which explores betrayal trauma in its societal implications and suggests ways for us to heal our blindness and pain of betrayal— institutional and otherwise.

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## Congratulations to the 2012–2013 Newly Elected ISTSS Leadership

### **ISTSS President-Elect:**

Nancy Kassam-Adams, PhD

### **ISTSS Board Members:**

Diane Elmore, PhD, MPH

Julian Ford, PhD

Yoshiharu Kim, MD, PhD

Harold Kudler, MD

Candice Monson, PhD

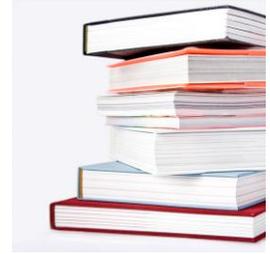
Miranda Olf, PhD

Congratulations to the new president-elect and board members.

Thanks to the nominees and ISTSS members who participated in the election.



## Trauma and World Literature: Poetry from an ISTSS Member



Poetry from past wars focused primarily on poignant, often gristly battlefield scenes but modern war poetry has begun to shift its focus to the home front; a point well illustrated by this latest offering from poet and retired Army Colonel Elspeth Cameron Ritchie. Her poem, *A Veteran and His Dog*, written during her own transition from service as one of the United States military's senior consultants on behavioral health to her current role as chief clinical officer for Washington D.C.'s Department of Mental Health (see this column in *Traumatic StressPoints*, 26(1):10-11, January 2012), reflects that war follows the warriors home.



### **A Veteran and His Dog, 2011**

My sign, outside Union Station, said  
"Homeless Vet, I am hungry".  
Just another ragged man.  
"Can you spare some change?"

I did not want to end up this way.  
When I enlisted, fleeing Kentucky,  
My uniform was crisp and tight.

I shipped to Iraq to fight,  
Smoked menthol cigarettes before convoys,  
Kicked down doors in SADR City,  
Manned checkpoints for hours  
Aiming, waiting, before I shot.

I killed bad guys, avoided women,  
But once hit a boy of two.  
I befriended a feral pup named Zach,  
The Haji guards blasted him when  
Blue-eyed Zach barked too much.

I re-upped, went to Kandahar.  
Ferocious nightmares started then:  
Rage over the tattered dead friends.  
Neither Combat Stress Control or tattoos helped.  
I kept dreaming of the boy and a  
bloated donkey in the ditch,  
worms in the eyeballs.

*Trauma and World Literature* continued from page 6

I was caught smoking hashish.  
Dishonorably discharged, scarlet letters  
stamped across my paperwork.

I cannot get VA treatment,  
which I do not want  
(those pudgy social workers)  
nor jobs, apartments or  
garden plots, which I do.

I bussed to Washington to plead my case.  
I served in two theaters of war,  
Why should one hot piss test  
scar six years of service?

No money for a bus back to Kentucky.  
Besides I have my pride.  
So I huddled for three years,  
outside Union Station, while pinstriped  
suits and pink heels walked past.

I scorned the homeless outreach ministrations.  
Finally I accepted a card and a shower.  
Another vet gave me a hand up and a dog.

Now I have pressed flowers,  
Violets, yellow pansies, to sell.  
My saxophone blows out sharp blues,  
my black lab, Pride, sits by my feet.

People reach out and stroke him,  
buy my wares and drop in dollars.  
We take the Metro to my home.  
If I have nightmares, his cold nuzzle  
Wakes me, and the dreams switch to  
Gardens with basil and fairies.



## 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](mailto:HLipke@aol.com).

## 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!

## Consider Joining an ISTSS Special Interest Group!

ISTSS members have taken the initiative to form several special interest groups in order to facilitate networking, collaboration, and communication amongst colleagues with similar interests and areas of expertise. Many of these groups will be holding meetings during the Annual Meeting in November.

Please consider attending one or more of these SIG meetings in order to learn more about the good works they are doing! Visit the [ISTSS website](#) for more information or contact the SIG chairs listed below.

- **Aging, Trauma, & the Life Course SIG**, Eve Davison, PhD, [Eve.Davison@va.gov](mailto:Eve.Davison@va.gov)
- **Child Trauma SIG**, Marianne Kabour, [mkabour@pgsp.edu](mailto:mkabour@pgsp.edu)
- **Complex Trauma SIG**, Pam Alexander, [palexand@wellesley.edu](mailto:palexand@wellesley.edu); Chase Stovall-McClough, [chasemcclough@hotmail.com](mailto:chasemcclough@hotmail.com)
- **Creative, Body, Energy Therapies SIG**, David Read Johnson, PhD, [hadardavid@aol.com](mailto:hadardavid@aol.com); Amber Elizabeth Gray, [amber@ecentral.com](mailto:amber@ecentral.com)
- **Criminal Justice SIG**, Susan Mirow, MD PhD, [susanmirow@aol.com](mailto:susanmirow@aol.com)
- **Dissemination & Implementation SIG**, Shannon Wiltsey Stirman, PhD, [Shannon.Wiltsey-Stirman@va.gov](mailto:Shannon.Wiltsey-Stirman@va.gov); Delyth Lloyd, MA, [d.lloyd@unimelb.edu.au](mailto:d.lloyd@unimelb.edu.au)
- **Diversity & Cultural Competence SIG**, Bitu Ghafoori, PhD, [bghafoor@csulb.edu](mailto:bghafoor@csulb.edu); Stefanie Smith, [ssmith@stefaniefishsmithphd.com](mailto:ssmith@stefaniefishsmithphd.com)
- **Early Interventions SIG**, Josef I. Ruzek, PhD, [josef.ruzek@med.va.gov](mailto:josef.ruzek@med.va.gov); Patricia Watson, PhD, [patricia.j.watson@dartmouth.edu](mailto:patricia.j.watson@dartmouth.edu)
- **Family Systems SIG**, Briana S. Nelson Goff, PhD, [bnelson@ksu.edu](mailto:bnelson@ksu.edu); Laurel J. Kiser, [lkiser@psych.umaryland.edu](mailto:lkiser@psych.umaryland.edu)
- **Gender & Trauma SIG**, Jaimie L. Gradus, DSc, MPH, [Jaimie.Gradus@va.gov](mailto:Jaimie.Gradus@va.gov); Katherine M. Iverson, PhD, [Katherine.Iverson@va.gov](mailto:Katherine.Iverson@va.gov)
- **Genomics & Trauma SIG**, Ananda Amstadter, PhD, [abamstadter@vcu.edu](mailto:abamstadter@vcu.edu); Nicole Nugent, PhD, [nicole\\_nugent@brown.edu](mailto:nicole_nugent@brown.edu)
- **Human Rights & Social Policy SIG**, Leilani Kuuipo Ordway, [weinotbelle@aol.com](mailto:weinotbelle@aol.com); Rouguiatou Diallo, M.Sc, [rouguiatoud@yahoo.com](mailto:rouguiatoud@yahoo.com)
- **Intergenerational Transmission of Trauma and Resilience SIG**, Maria Yellowhorse Braveheart, PhD, [mbraveheart@salud.unm.edu](mailto:mbraveheart@salud.unm.edu); Mary Armsworth, PhD, [armsworth@uh.edu](mailto:armsworth@uh.edu); Andrei Novac, [anovac@uci.edu](mailto:anovac@uci.edu)
- **Internet & Technology (I&T) SIG**, Prof. Charles R. Figley, PhD, [Figley@Tulane.edu](mailto:Figley@Tulane.edu)
- **Lesbian, Gay, Bisexual & Transgendered Issues SIG**, Edward Alessi, PhD, [ealessi@ssw.rutgers.edu](mailto:ealessi@ssw.rutgers.edu); Laura Johnson, PsyD, [nineelephants@gmail.com](mailto:nineelephants@gmail.com)
- **Media SIG**, Patrice Keats, [pkeats@sfu.ca](mailto:pkeats@sfu.ca); Cait McMahon
- **Military SIG**, Kathleen Chard, PhD, [kathleen.chard@va.gov](mailto:kathleen.chard@va.gov)
- **Psychodynamic Research & Practice SIG**, Lutz Wittmann, PhD, [lutz.wittmann@usz.ch](mailto:lutz.wittmann@usz.ch)
- **Research Methodology SIG**, Brian J. Hall, PhD, [bhall41@gmail.com](mailto:bhall41@gmail.com); Jodi B. A. McKibben, PhD, [jodibam@gmail.com](mailto:jodibam@gmail.com)
- **Spirituality SIG**, Kathleen Chard, PhD, [kathleen.chard@va.gov](mailto:kathleen.chard@va.gov)
- **Terrorism and Bioterrorism Related Trauma SIG**, Ginny Sprang, PhD, [sprang@uky.edu](mailto:sprang@uky.edu)
- **Theory & Traumatic Stress Studies SIG**, Charles C. Benight, PhD, [benight@uccs.edu](mailto:benight@uccs.edu)
- **Trauma Assessment & Diagnosis SIG**, J. Richard Monroe, [J.Richard.Monroe@va.gov](mailto:J.Richard.Monroe@va.gov); James Naifeh, [james.naifeh@gmail.com](mailto:james.naifeh@gmail.com)
- **Traumatic Loss & Grief SIG**, Alison Salloum, [asalloum@usf.edu](mailto:asalloum@usf.edu)
- **Trauma & Substance Use Disorders SIG**, Anka Vujanovic, PhD, [anka.vujanovic@gmail.com](mailto:anka.vujanovic@gmail.com); Marcel Bonn-Miller, PhD, [mbonnmil@gmail.com](mailto:mbonnmil@gmail.com)

## Mechanisms of Psychological Harm Following Human Rights Violations and Torture

**Angela Nickerson**

*School of Psychology, University of New South Wales*

**Richard A. Bryant**

*School of Psychology, University of New South Wales*

**Brett T. Litz**

*VA Boston Healthcare System, Massachusetts Veterans Epidemiological Research and Information Center, Boston University*

Human rights violations (HRVs) occurring in the context of mass violence, genocide, and conflict have an enduring impact on individuals and communities. The deleterious effects of exposure to HRVs such as killing, atrocities, torture, and rape are compounded by the inaccessibility of recovery and healing resources as a result of loss, displacement, and cultural and religious dislocation. Research on the psychological effects of HRVs has focused on posttraumatic stress disorder (PTSD) and depression, reporting elevated rates of these disorders amongst HRV-affected populations (Fazel, Wheeler, & Danesh, 2005; Johnson & Thompson, 2008; Steel et al., 2009). Clinical evidence, however, has suggested that psychological responses to these events extend beyond the scope of current diagnostic categories.

Other documented effects of HRVs include alterations in self-concept, agency and perceptions of control; enduring feelings of humiliation, shame, anger, and betrayal; and changes in capacity to relate to others (e.g., Basoglu, Livanou, & Crnobaric, 2007; Gorst-Unsworth, Van Velsen, & Turner, 1993; Silove, 1999; Turner & Gorst-Unsworth, 1990). Despite the widespread acknowledgment of the profound psychological effects of HRVs, research has focused on investigating the prevalence of mental disorders rather than considering mechanisms that underlie psychosocial outcomes. It is notable that while survivors of HRVs evidence high rates of psychological disorders, studies have consistently identified a substantial group of trauma-exposed individuals without significant disorder and/or impairment. The investigation of mechanisms underpinning adaptation following HRVs is of key importance as knowledge of the pathways that lead to psychological symptoms would facilitate the identification of targets and intervention strategies to promote resilience and recovery.

With the goal of facilitating discussion and research, we propose three pathways that underpin the negative effects of HRVs on psychosocial outcomes. While HRVs undoubtedly impact on various domains, including biological, spiritual, and societal, here we are concerned with mechanisms underlying psychological dysfunction

following HRVs, thus these pathways are limited to psychological processes. The three pathways include (a) disturbances in interpersonal processes, (b) altered perceptions of control, and (c) disruptions in individual and group identities.

Changes in these core functions are also compounded by the post-HRV environment which is often characterized by continued threat, dislocation, instability, and uncertainty. While these pathways have been observed anecdotally, there has been a dearth of systematic empirical research examining these factors in the context of HRV-related mental health.

HRVs often involve exposure to multiple instances of interpersonal violence, such as assault, rape, and torture. Accordingly, researchers have noted that HRVs challenge conceptions of the benevolence of humankind, and negatively impact on interpersonal trust and functioning (e.g., Basoglu, 2009; Basoglu et al., 2005; Gorst-Unsworth et al., 1993). Exposure to frequent and sustained interpersonal violence, particularly in contexts where it is unclear who is a member of the perpetrating group (and misplaced trust can have catastrophic consequences), may cause pervasive changes in the survivor's capacity to trust others. Suspicion of others' intentions and negative expectations of behavior often endure even in sustained circumstances of safety. While this may be adaptive in the context of HRVs by facilitating avoidance of potential harm and betrayal, it is likely to contribute to interpersonal difficulties in objectively safe environments such as countries of resettlement.

This phenomenon is outlined in constructivist theories that highlight the importance of beliefs about the benevolence and trustworthiness of others in forming and maintaining social relationships (e.g., Epstein, 2003; Janoff-Bulman, 1992), and supported by evidence from studies with trauma survivors revealing that interpersonal trauma negatively impacts relational motivation, social repertoires, and attachments (e.g., Alexander et al., 1998; Cloitre, Stovall-McClough, Zorbach, & Charuvastra, 2008; Roche, Runtz, & Hunter, 1999). The impact of HRVs on interpersonal

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expectations and processes thus represents an important potential pathway from trauma exposure to psychosocial functioning.

HRVs often impose a profound sense of helplessness on the victim, as he or she is stripped of control and subject to repeated and unpredictable instances of persecution and violence. This sense of helplessness may also be compounded by lack of control in other areas of the survivor's life, for example, via forced displacement or inability to protect loved ones from deprivation and violence. Torture is an example of an event characterized by extreme uncontrollability, and research has suggested that lack of control is an especially damaging aspect of torture, contributing to psychological outcomes over and above the objective severity of physical torture (Basoglu, 2009; Başoğlu & Livanou, 2008).

Models of traumatic stress have historically considered the role of perceptions of control in causing traumatic stress (Ehlers & Clark, 2000; Foa, Zinbarg, & Rothbaum, 1992; Frazier et al., 2011; Janoff-Bulman, 1989). While findings regarding the relationship between perceived control at the time of the traumatic event and subsequent wellbeing have been mixed (see Frazier et al., 2011), research has consistently indicated that perceived lack of control over one's current and future circumstances is associated with poorer outcomes (Burke Draucker, 1989; Grills-Taquechel, Littleton, & Axsom, 2011; Hazzard, 1993).

Severe and repeated stress-induced changes in agency following exposure to uncontrollable stress are outlined in the "learned helplessness" theory of depression (Overmier & Seligman, 1967; Seligman & Maier, 1967). Studies applying this construct to humans have indicated that perceived control over an aversive outcome is associated with lower physiological arousal, fear, distress, and performance impairment in response to subsequent stressors (Geer, Davison, & Gatchel, 1970; Glass et al., 1973; Litt, Nye, & Shafer, 1993). These findings have substantial implications for survivors of HRVs, as they suggest that beliefs about control may be negatively influenced by traumatic events, and implicated in subsequent adaptation.

HRVs are often enacted on the basis of identification with an ethnic, political, religious, cultural, or other group, with the goal of denigrating this identity through persecution, devaluation, and dehumanization. Consequently, survivors of HRVs may experience challenges to their sense of self-worth and conceptions of group and individual identities (Barudy, 1989; Chodoff, 1959; Silove, 1999; Weine & Laub, 1995).

Accordingly, theorists have asserted that exposure to interpersonal trauma profoundly affects identity and self-worth (Janoff-Bulman, 1992), with the construct of "permanent change" describing the feeling of being irreversibly damaged or altered following trauma (Dunmore, Clark, & Ehlers, 1999).

Not surprisingly, self-esteem and self-worth have been found to mediate the association between trauma exposure and PTSD and other symptoms of mental distress (Grills-Taquechel et al., 2011; Nixon & Nishith, 2005; O'Donnell, Elliott, Wolfgang, & Creamer, 2007). Further, research has suggested that low self-worth is associated with numerous other negative psychological and social outcomes (Holden, 1991; Nesdale, Rooney, & Smith, 1997; Park & Maner, 2009; Solberg & Villarreal, 1997). In the context of HRVs, group identity, previously a source of pride and belonging becomes the basis upon which violence and persecution are enacted.

The denigration of group identity is often a strategic goal, particularly in settings of genocide or ethnic cleansing, presenting formidable challenges to the maintenance of positive and cohesive group identities. Positive group identity has been strongly linked to self-concept, belongingness, and collective self-esteem (Tajfel, 1981; Tajfel & Turner, 1979; Verkuyten & Lay, 1998); which are, in turn, associated with good psychosocial outcomes (Bettencourt & Dorr, 1997; Crocker, Luhtanen, Blaine, & Broadnax, 1994; Lam, 2007). The capacity of HRVs to profoundly alter individual and group conceptions of identity represents an important pathway from traumatic events to adaptation and recovery.

Research predominantly undertaken with refugees has indicated that the posttrauma environment contributes strongly to psychological recovery (see Porter & Haslam, 2005). We propose that the post-HRV context may interact with psychological symptoms via the three pathways detailed above, by creating an environment that precludes or greatly complicates recovery. For example, the impact of interpersonal violations may be compounded in post-trauma environments where conflict is ongoing, trust in others is inadvisable, and the individual is separated from important support networks.

Lack of control may be further manifested in resettlement countries by immigration detention, protracted asylum claims, or the threat of being returned to the site of the violence. Individual identity may be further compromised by dehumanizing settings such as refugee camps and detention centres, and changes in status and identity in new settings. Group identity may be damaged via displacement from cultural and religious communities, and impaired capacity to perform rituals important to the

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maintenance of group identity due to cultural destruction or logistic challenges.

We have integrated theoretical perspectives and diverse lines of research to propose three pathways from exposure to HRVs to psychosocial outcomes, with the goal of promoting discussion and investigation of mechanisms underlying the psychosocial effects of trauma in the context of mass violence, genocide and conflict. Further research exploring these pathways represents a promising avenue for increasing understanding of the impact of HRVs on mental health, and the development of effective interventions to facilitate adaptation and recovery.

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## Comment Period Open for the Complex PTSD Treatment Guidelines for Adults

ISTSS members have an opportunity to comment on proposed Complex PTSD Treatment Guidelines for Adults developed by the ISTSS Complex Trauma Task Force. The comment period is now open. Each ISTSS member may submit one electronic comment on these guidelines. The purpose of this feedback process is to encourage all members to review the guidelines and comment on them in light of best current evidence.

Please visit the [ISTSS website](#) to access the guidelines and make comments. (Member log in required.) The site will be open for comment until Friday, September 28, 2012.

## Media Matters: Understanding Guilt, Shame, and Personal Growth Among Journalists Covering Disaster

**Meg Spratt, PhD**

*Associate Director for Academic Programs at the Dart Center for Journalism and Trauma at the University of Washington*

Trond Idås, journalist, researcher, and adviser for the Norwegian Union of Journalists, has led efforts to examine stress and trauma reactions experienced by journalists who have covered large scale trauma, including the devastating 2004 Asian tsunami and the July 22, 2011, attacks that left 77 dead in Norway.

In addition to conducting a survey of 63 Norwegian journalists who covered the devastating tsunami, Idås has surveyed more than 500 journalists who reported on the July 22 Oslo bombing and mass murder at a youth camp on the island of Utoya. Results unveil both feelings of guilt and shame among journalists who covered the tragedies, as well as effective coping mechanisms and opportunities for personal growth.

In this interview, Idås discusses the findings and implications of his survey research with Meg Spratt, University of Washington communication researcher and lecturer.

### **What were the primary findings in your survey of journalists who covered the 2004 Tsunami?**

**Idås:** The survey was part of a comprehensive research program on disaster victims and first responders performed by the Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS) in Oslo.

The survey investigated the potential stressful experiences faced by first responders and journalists in the disaster area, such as witnessing experiences/grotesque impressions, ethical dilemmas and demanding working conditions.

Results indicated that the journalists, compared to first responders, were far more exposed for grotesque impressions of the disaster scene. It also showed that experiencing ethical dilemmas such as breaking their own ethical standards, and leaving the disaster victims behind when going home to Norway, were strongly associated with stress reactions, even more than witnessing traumatic events. Stress reactions were also associated with lack of preparation, rest and sleep, and goal oriented work.

The results indicate that most media personnel coped well with the challenges of the tsunami disaster. However, the survey also shows that the journalists experienced significantly higher levels of stress reactions than first responders – still with a mean score at a relatively low level. At the same time most journalists perceived the disaster work experience as meaningful and successful.

### **What specific elements of the tsunami coverage were most difficult for journalists?**

**Idås:** The survey focused on three different factors which gave the journalists major challenges in the coverage of the tragedy. The first two factors are closely connected to a journalist's role as society's eyewitness and informant.

It is the journalist's job to seek the victims and the survivors of the disaster, to tell the world about the scale of the tragedy and the need for help, and to get the survivors' own stories about their struggle for life and the grief of those left behind. More than 230,000 people died because of the tsunami. Several hundreds of thousands were injured. So, it is no wonder that journalists were heavily exposed to graphically violent images.

Meeting with survivors and the bereaved also presented ethical dilemmas for journalists, especially since many journalists arrived in the disaster area the first days, while the situation was chaotic. The first dilemma was that they were not there to provide aid for those who needed help. Rather, they were there to ask survivors for their story. Though this is a key role for journalists, many also felt like intruders.

Journalists also faced ethical dilemmas concerning what to publish. How far should they go in their description of thousands of bodies lying for days in the sun? How detailed should the stories about survivors be without offending

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their integrity? These are tough decisions to make in the field, especially since editors back home often expected exclusive and strong personal stories.

The third factor was working conditions. The major problem was lack of rest, both because of the endless need for information and stories and the eight-hour time difference between Norway and Thailand. To get their stories in the disaster area, where most of the infrastructure was washed away, the journalist had to start early in the morning local time, while prime time TV news back in Norway was in the middle of the night in Thailand.

### **How do your findings inform your work with journalists who covered the July 22 tragedy in Norway?**

**Idås:** The tsunami study included only a few questions covering ethical dilemmas. The results indicated that these factors might be a major reason for stress reactions in two ways: They challenge your self-esteem, and it is difficult to discuss (and defuse) these kinds of experiences with colleagues and peers due to traditions and culture in the newsroom.

My new study on the journalists who covered July 22 is based on the tsunami study, expanded with new questions on two topics: The ethical dilemmas of journalists covering stories involving human grief, injuries and casualties, and professional and personal growth covering this kind of incident.

The last part is important, since quite a few of the journalists have high scores both on stress reactions and growth. When asked in what degree they were glad to take part in the coverage, the average score for those who were out in the field on July 22, is 6.2 on a scale from 1-7 (7=Very glad). More than half of the journalists reported that they have experienced personal and professional growth.

### **What coping mechanisms seem to work best for journalists covering large-scale trauma?**

**Idås:** The journalist's own answer is: "To talk with colleagues who covered the story." They often find it stressful to talk with people who do not have first-hand experience covering these types of trauma.

Another interesting finding is that journalism in itself appears to have a "therapeutic" effect. The journalist's job is to put the pieces together, making people understand how the catastrophe could happen. This gives a kind of control of the chaotic situation, and the job feels important and meaningful. All these factors are important for coping.

Support and recognition for the job they are doing, both from the public, their peers and colleagues, is also important. The journalist's self-esteem and self-image are under pressure covering this kind of story, knowing that they are in a position where they can make the situation even worse for the survivors and those left behind, and knowing the important roles of the media covering large-scale trauma.

### **Do emotional reactions seem to differ for journalists covering a human-caused tragedy as opposed to a natural disaster?**

**Idås:** The results from the Impact of Event Scale (IES-22) show a significant difference between journalists who covered the tsunami and those covering July 22. Both surveys are done about nine months after the incident. The average scores for the tsunami journalists reporting stress and trauma reactions were lower than those who were out in the field July 22.

I guess this is both about the difference between catastrophes caused by natural disasters and caused by human evil, and that a lot of the journalists worked almost full time covering July 22 all the way from the incident to the trial, which began a few days after I closed the survey.

### **Drawing from your research, what do you think mental health clinicians who work with journalists need to know about the effects of covering large-scale trauma?**

**Idås:** The reactions are the same for journalists as for first responders, but the reason for problems might be a little different. In addition to reactions after witnessing experiences, quite a few journalists feel shame and guilt after the coverage. Some blame themselves for the way they have asked questions, or for contacting victims or the bereaved.

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About one of five journalists say they have encountered aggression or violence while doing their job.

These experiences strengthen feelings of guilt and shame and are often hard to talk openly about with colleagues and peers. It might be easier to talk with professionals. Journalists sometimes become close to the victims and the families hit by sorrow. This makes it difficult to keep the professional distance to the grief; the journalist is traumatized almost like a member of the family.

### **What do news managers need to know?**

**Idás:** First, it is important to think through who they are sending out in the field. On July 22, about 40 percent of the journalists covering the story had five years or less experience. One out of four were students working for the summer.

The surveys show that work experience is one of the major factors for coping, and that less experienced journalists had significant more problems than experienced. My advice to news managers is to put together teams including journalists with different levels of experience, giving the experienced journalist the role of mentor and adviser.

It's important for news managers to follow up with journalists, both those out in the field and those on the news desk (especially those receiving photo and video footage), to help with the coping process. The news managers have a key role, giving social support and recognition. Effective strategies include arranging meetings to sum up the coverage, inviting mental health professionals to discuss stress reactions and coping mechanisms, and offering professional help to those who need it.

The goal should be to contribute in a way that gives as many journalists as possible ways to grow personally and professionally from the coverage, making them better prepared for the next demanding personal or professional situation.



## **ISTSS Board Sponsors Local Scholarships**

This year, the members of the ISTSS Board of Directors have donated \$10,000 to ISTSS, and these funds will be used to sponsor 15 Local Scholars.

ISTSS Local Scholarships are used to support mental health or social service professionals or students who provide services to underserved trauma-exposed populations in the host city or the geographical region of any ISTSS annual or one-day meeting. The scholarships are intended to provide training in traumatic stress to mental health or social service professionals or students who would benefit from it, but are not able to afford to travel or register for the ISTSS meeting.

Scholarships for the 2012 Annual Meeting will include registration for the annual meeting and for one full-day or two half-day Pre-Meeting Institutes.

Please share this opportunity with colleagues in the LA area who may be eligible. Application instructions can be found on the [ISTSS Website](#).

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