



President's Column

Ulrich Schnyder, MD
President

In my last column, I spoke about the incident on Delta flight number 253 from Amsterdam to Detroit on Christmas Day that happened shortly before the January *Stresspoints* issue was published. I didn't expect that shortly after that, a major disaster would hit the world. The Haiti earthquake of January 12 took the lives of more than 200,000 people, and left a whole country bereaved and traumatized.

Moreover, on February 27, another devastating earthquake struck Chile. Let's take a few seconds, and think of the many fellow human beings who are now living in these areas under extremely difficult conditions, struggling to cope with a situation they had hardly anticipated.



March 1, 2010 - A man moves a mattress in the city of Constitution. (L.A. Times)

Clearly, traumatic stress can affect everyone, anywhere, at any time. We know that some of those affected will go on to develop posttraumatic morbidity. We also know that in the aftermath of trauma, amazing examples of resilience and posttraumatic growth can

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be observed. However, much remains to be understood in greater detail in order for professionals to be able to respond appropriately to those who are in need of our help and support.

The accumulation and dissemination of knowledge about traumatic stress is typically done in interdisciplinary collaboration. This is why ISTSS provides a forum for clinicians, researchers and other professionals across a wide range of disciplines.

Speaking of collaboration: Two ISTSS **clinician-researcher learning collaboratives** have been successfully launched using both phone conferencing and web-based communications to implement evidence-based treatments.

The interactions are going well, with positive responses in the groups to using Web-based social networking as a means of communication. For more information, go to the ISTSS online learning collaboratives section of the Web site:

http://www.istss.org/Learning_Collaborative/1588.htm.

Thanks to ongoing support by ISTSS Headquarters, the collaboratives are working smoothly.

The Risks and Benefits of Learning about Trauma

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Researchers have become more sophisticated in thinking about the risks and benefits of asking people to participate in trauma-focused research (e.g. DePrince & Freyd, 2004; Griffin, Resick, Waldrop, & Mechanic, 2003; Johnson & Benight, 2003; Newman & Kaloupek, 2004; Newman, Risch, & Kassam-Adams, 2006), as well as the risks of *not* doing this research (Becker-Blease & Freyd, 2006).

There are some similarities between the concerns for human research participants and college students taking trauma-focused classes, such as psychology of trauma, child abuse and neglect, and violence against women. In fact, in IRB applications, some trauma researchers explicitly compare the risk of participating in trauma-focused research on university campuses with the risks to students who are routinely exposed to trauma in a wide range of college classes. If students are routinely confronted with films, readings and discussions about trauma without informed consent or the guarantee of voluntary participation in classrooms, then the risk of asking students about trauma in a research study is likely lower than participants' everyday experiences.

This is a logical argument that we ourselves use in IRB applications. At the same time, we need to collect better empirical data on the actual and perceived risks and benefits of research *and* of being exposed to trauma-related material in college classrooms. We simply cannot do research or teach ethically without knowing how our work affects people. In the rest of this article, we lay out some important concepts from the literature on the risks and benefits of trauma-focused research that can inform (and hopefully inspire new empirical research on) the effects of learning about trauma in college classes.

...we need to collect better empirical data on the actual and perceived risks and benefits of...being exposed to trauma-related material in college classrooms.

“distress” and “harm.” In short, distress is a normal reaction to being exposed to trauma. Students who leave a trauma-focused class desensitized to suffering are not in a position to cope with their own reactions to trauma, or to take steps to reduce suffering in the world. We run the risk of sparing our students feelings of distress, while leaving them less able to cope and reduce real harm in the world. On the other hand, overwhelming distress can cause harm, such as when students experience such intense sadness or anxiety that they harm themselves. Any meaningful research into the effects of teaching about trauma must carefully disentangle these two concepts.

Second, it is helpful to assess both the risks and benefits to students taking trauma-focused classes. One risk is becoming overwhelmed with distress, resulting in a feeling of hopelessness. Some benefits to students include a new awareness of the effects of trauma for individuals and groups of people and increased capacity for empathy and activism.

Third, we can best meet students' needs by acknowledging their different motivations for taking trauma classes. Consistent with past research with research participants and sexual abuse survivors seeking health care (e. g. Newman, Risch, & Kassam-Adams, 2006; Seng, Sparbel, Kane Low, Killion, 2002), we suggest that we keep in mind that abuse survivors vary widely in their own mental health, coping strategies and expectations from professionals with whom they interact. As a start, we suggest considering both students' personal connections to trauma (e.g. personal and family history) and their understanding of trauma in society. Some students have little awareness of the impact of trauma either in their own lives or in society in general. On the first day, these students say they've never thought about trauma before. On the other hand, some clearly explain the role trauma has played in both their personal lives, and in society.

These trauma survivors are often active in organizations to help other trauma survivors. In addition, some are clear about their personal history, but have yet to connect it to trauma in society at large. These students sometimes have difficulty understanding other students' reactions to trauma when those reactions differ from their own.

Risks continued from page 2

Finally, some students come with an awareness of trauma in society, but are lacking a full understanding of the effects of trauma in their own lives. These students are sometimes interested in campaigns to increase lighting on campus, or to protect domestic violence victims, projects that sometimes fail to take into account the voices of survivors themselves.

Research is needed to better understand the experiences of students with different backgrounds and motivations in trauma classes. In the meantime, we can consider the following:

- ❖ Teach early in the class about vicarious trauma, and how to cope with distress. Have a representative from campus counseling services attend class to explain available services.
- ❖ Teach explicitly about the ways that individuals and societies tend to keep themselves from being aware of trauma in their lives and communities as a way of actively engaging students in the work of facing difficult topics. Carefully chosen guest speakers can be helpful for modeling the balance between personal reactions and professional and public responses to trauma.
- ❖ Provide assignments with options for students with varying levels of awareness and knowledge about trauma. Activism projects will appeal to some, but may be overwhelming for others, and could have iatrogenic effects if students are asked to complete projects for which they are not prepared.
- ❖ At various points throughout the term, and especially at the end, show students reason for hope. Careful thinking and research has improved trauma-focused research, and we are poised now to gain similar insight into the teaching of trauma.

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Colonialism and Trauma: Intersections of the Past and Present

Marissa N. Petersen, MA

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While each colonized geographic area has been left with traumatic consequences specific to its culture, cosmology, and political history, research has indicated that some phenomenological experiences of colonization may be universal (Menon & Bhasin, 1998; Judd, 2004; Freire, 1970; McLucas, 2005; Buckley-Zistel, 2006). Despite the remarkable resiliency of these populations, the oppression and trauma inherent in colonization imposes a loss of individual, communal, and national identity (Ganguly, 1994; Menon & Bhasin, 1998; Judd, 2004; Harding, 2006; Matory, 2007; Grey & Manning, 2007). Further, the trauma experienced by individuals and whole communities is often passed on in some way to succeeding generations (Danieli, 1998; El Bushra & Mukarubuga, 1995; Kaitz, Levy, Ebstein, Faraone & Mankuta, 2009). Thus, the psychological effects of colonization transcend first-hand experience. This article highlights the importance of community-based trauma interventions that validate the phenomenological experiences of non-Western individuals and empower these individuals to transcend oppressive neo-colonial conditions. Specific examples from the Indian sub-continent, Rwanda and Afro-Brazil are utilized.

Post-Colonial Trauma in the Indian Subcontinent

Colonialism existed in India as early as the 1500s with the Portuguese, Dutch, Danish, French and British all establishing colonies in the region (Judd, 2004). In 1857, British India was comprised of present day India, Pakistan and Bangladesh. During Independence, Great Britain partitioned the colony on the basis of religion. Thousands of families were divided and villages were destroyed. The estimates of the number of deaths were approximately 500,000, with low estimates at 200,000 and high estimates at 1,000,000 (Menon & Bhasin, 1998). Among those who survived the violence of the Partition, many lived as refugees in their new country. More than 60 years post Partition, the root cause of wars within the sub-continent is attributed to the animosity between Hindus and Muslims and disputes over borders which surfaced during the Partition (Ganguly, 1994).

Post-Colonial Trauma in Rwanda

Rwanda's long history of colonial oppression dates back to the German (1893-1923) and Belgian rule (1923-1962). This small country is perhaps most known for the horrific

genocide of 1994. The root causes of this genocide are best understood within the context of the country's complex history, particularly through the influence of the Catholic Church during the Belgian colonial rule (Kubai, 2007). The church-dominated socio-political system, implemented by colonial rule created a sharp division in status among Rwandans, granting the Tutsi ethnic minority superiority over the Hutu and Twa (Kubai, 2007). In response to this externally imposed hierarchy, approximately 800,000 to 1,000,000 Tutsi citizens were massacred in a span of 100 days by their Hutu countrymen. Despite national reconciliation efforts, even today mistrust of one's neighbors and the lack of a general sense of safety pervade Rwandan communities.

Post-Colonial Trauma in Afro-Brazil

The transatlantic slave trade transported an estimated 3.5 million Africans to the coasts of Brazil to work on Portuguese sugar plantations. Brazil was one of the last countries in the Americas to abolish slavery on May 13, 1888. The remnants of slavery continue to plague the Afro-Brazilian community via police brutality, community violence, kidnappings, and extortion (Vargas, 2004, 2005, 2006). Notably, the United Nations Index of Human Development, which is utilized as a measure of life quality on a scale of 0-1, resulted in 0.796 for the Brazilian population as a whole and 0.573 for Afro-Brazilians (Vargas, 2005, p. 282). The historical segregation of individuals of African descent in Brazil has left scars, not only on Afro-Brazilians, but also the greater Brazilian society.

Universality of the Transmission of Trauma

The implications of trauma are not restricted to the immediate victims, but also have an impact on later generations of trauma survivors (Kaitz, et al., 2009, p. 160). For example, within the gendered power structure in Rwanda, it is the responsibility of the women to construct or maintain intergenerational relationships through the child-rearing process (El-Bushra et. al., 1995). Due to these mothers' experience of genocide, current handing down of identity and knowledge may require Rwandan women to inform the children of the historical context of the war. This may make Rwandan women feel as if they are keeping the conflict 'alive' within themselves (El-Bushra et. al., 1995).

Colonialism continued from page 4

Danieli (1998) suggests that socio-political climate, culture, parents' trauma, the "conspiracy of silence," and the families' posttraumatic adaptation style contribute to how trauma is transmitted. Past research suggests that a multidimensional, multidisciplinary integrative approach to understanding trauma and its multigenerational transmission is essential (Danieli, 1998). Resources such as *The International Handbook of Multigenerational Legacies of Trauma* (Danieli, 1998) provide a framework for practitioners to utilize when treating survivors of these catastrophic events.

The implications of trauma are not restricted to the immediate victims, but also have an impact on later generations...

Community-Oriented Recommendations

When working with children, adolescents and families from countries impacted by colonialism, culturally-sensitive clinicians need to develop an understanding of the history of the individual's country of origin as well as the individual's experience of this history (Sue & Sue, 2008). While Herman (1992) suggests increasing connection between the survivors and the community, Danieli (1998) emphasizes the need to break the "conspiracy of silence" (p.4) and underscores the need for a multidisciplinary understanding of trauma. Research has indicated that interventions that are coordinated on the district level using a community-oriented approach have higher rates of long-term effectiveness than those that act independently (Chauvin, L., Mugaju, J., & Comlavi, J., 2005). It is only after a safe space is provided by mental health providers and the communities, survivors can tell their stories, process their trauma and communicate adaptively with later generations.

Methods for incorporating indigenous values include accessing the work of traditional healers (Chauvin et.al, 2005) and understanding of large-group approaches to healing, such as testimonials and commemoration (Volkan, 2000) would be more appropriate or effective than adhering to an individual treatment approach. Ultimately, colonization is a form of group oppression; therefore, healing may necessitate a group process. Activities that incorporate movement, music, drawings, and story-telling may be useful as these activities offer

the opportunity both for engagement with experience and reconnection to pre-colonial traditions. A community-oriented approach to healing that acknowledges the subjectivity of trauma experiences among non-western post-colonized nations is particularly relevant to the future of psychology.

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Trauma and World Literature

On Compensation: *The Sweet Hereafter* Revisited

Howard J. Lipke, PhD

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This is the third reference to Russell Banks' *The Sweet Hereafter* to appear in this column. The book was quoted in our initial column on the subject of numbness or, perhaps, detachment that often follows trauma. Next, Harold Kudler mentioned the film version in his top ten list, and I concurred. This may be one of the few examples of a film being at least as good as the great book on which it is based. This third reference is a quotation from the book, in the voice of the attorney who is suing the town on the behalf of victims of a school bus accident. The impetus for inclusion of this passage is that it is the only literary example I have seen that addresses an important issue in our field that is not often publically discussed by mental health professionals.

"I know that in the end a million dollar settlement makes no real difference to them [the victims and their families], that it probably only serves to sharpen their pain by constricting it with legal language and rewarding it with money, that it complicates the guilt they feel and forces them to question the authenticity of their own suffering. I know all that: I've seen it a hundred times" (p. 98).



ISTSS Featured 2009 Award Recipient

Chaim and Bela Danieli Young Professional Award

ISTSS honored **Matthew T. Tull** with the Chaim and Bela Danieli Young Professional Award at the 25th Annual Meeting in Atlanta in November. Dr. Tull's work focuses on factors associated with the development, maintenance, and treatment of anxiety disorders, with a particular emphasis on PTSD and comorbid substance dependence. His research has examined the role that emotional avoidance and other difficulties with emotion regulation plays in the development of symptoms following exposure to a traumatic event, identifying important targets for treatment among trauma-exposed individuals, as well as a framework in which to conceptualize comorbid substance abuse and posttraumatic stress disorder (PTSD). His work on comorbid substance abuse and PTSD has been repeatedly funded by NIDA, indicating both the quality and the public health importance of this work.

Dr. Tull has published 29 peer-reviewed articles, and has 10 more manuscripts under review. He is also a skilled clinician who has treated veterans with PTSD, substance abuse, and a range of other comorbid presenting problems. He has received training in

This statement reflects the attorney's self-admitted perpetual rage, fueled by his inability to help his own estranged drug-addicted daughter. In his anger the lawyer neglects to point out that money from settlements may discourage negligence, may keep some people out of poverty or might improve the opportunity to heal. On the other hand, it is the rage which provides the power of the quoted insight.

Reference

Russell, B. (1991) *The Sweet Hereafter*. New York: Harper Perennial.



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.

behavioral and acceptance-based behavioral interventions and applies these models skillfully to complex clinical presentations associated with traumatic exposure.

His interest in traumatic stress began while he was in an experimental psychology masters program at Southern Methodist University. He conducted a methodologically rigorous, experimental study of the emotional/health effects of processing distressing events through writing and imagining (exploring Pennebaker's model of disclosure) as part of the completion of his Master's requirements. Dr. Tull became interested in the relationship between traumatic exposure, substance abuse and PTSD, which he pursued as an assistant.

Dr. Tull is now an assistant professor at the University of Mississippi Medical Center, where he is the director of Anxiety Disorders Research, and continues to pursue grant-supported research in the areas of PTSD and substance abuse.



The European Network for Traumatic Stress (TENTS)

Anke B. Witteveen, PhD; Jonathan I. Bisson, DM FRCPsych; Dean Ajdukovic, PhD; Kerstin Bergh-Johannesson, MSc; Norbert Gurrus, PhD; Venke Johansen, PhD; Dag Nordanger, PhD; Francisco Orenge Garcia, MD; Raija-Leena Punamaki, PhD; Aysen Ufuk Sezgin, PhD; Ask Elklit, PhD; Chris Freeman, MD; Louis Jehel, MD PhD; Maja Lis-Turlejska, PhD; Ulrich Schnyder, MD; Brigitte Lueger-Schuster, PhD; Lutz Wittmann, PhD; Miranda Olf, PhD

Clinicians and researchers in the field of trauma and PTSD have become increasingly aware of the need for consensus regarding evidence based effective interventions in the aftermath of disaster and implementation of these interventions (for reviews see Gersons & Olf, 2005; Hobfoll et al., 2007). At the same time, many countries and regions throughout Europe have limited expertise available and lack capacity to effectively respond to psychosocial needs in the aftermath of disasters. The European Union (EU) acknowledged these issues and demonstrated its support by co-funding the European Network for Traumatic Stress (TENTS) project. The general purpose of TENTS was to build Europe-wide networks of expertise on the psychosocial management of victims of natural and other disasters, and to help mental health services of provincial and district health authorities develop into more evidence based and effective services. TENTS consisted of nine associated partners (i.e. countries) and six collaborating partners throughout Europe. [Visit the TENTS](#) Web site for the full listing of associated partners.

The general purpose of TENTS was to build Europe-wide networks of expertise on the psychosocial management of victims of natural and other disasters, and to help mental health services of provincial and district health authorities develop into more evidence based and effective services.

Mapping post-disaster psychosocial care throughout Europe

To reach these goals, organizations and services involved in psychosocial management of victims of disasters throughout Europe were identified and a tool was developed to map psychosocial care for trauma- and disaster victims. In addition to visits to designated areas, a web-based questionnaire was completed by nearly 300 representatives from different organizations

throughout Europe. Data was gathered regarding background information, planning and coordination, target groups of psychosocial care, methods for screening and diagnosing, interventions, and training and supervision. We concluded that, in general, organizations from Central-Eastern Europe (and to a certain extent from Southern Europe) have a shortage of resources (e.g., in expertise and availability of evidence-based interventions) in the field of post-disaster psychosocial care. Exact needs, however, varied by country and organization. A detailed overview regarding psychosocial services for victims of disaster can be found on the TENTS website (www.tentsproject.eu). Some limitations need to be acknowledged as well. For example, in some areas very few organizations and services could be identified. Although this is a shortcoming, it may also reflect the situation that there actually are fewer services available in certain areas.

Systematic review

In parallel to the mapping of post-disaster psychosocial care, TENTS performed a systematic review of the evidence to create state-of-the-art guidelines for psychosocial care following disasters. Systematic literature searches and contact with specific individuals with expertise in the area were used to identify the information required. The systematic literature searches followed the methods designed by the Cochrane collaboration and the United Kingdom's Department of Health guideline on hierarchy of evidence (Mann, 1996). All pertinent information regarding the psychosocial management of victims of natural and other disasters in the following areas was gathered:

- a. immediate response,
- b. screening and diagnosis,
- c. preventive interventions,
- d. treatment of individuals with post-traumatic disorders.

The search regarding immediate response following disaster did not provide any high-level evidence and therefore, lower levels of evidence were identified and have been used to inform the development of existing guidelines (e.g. IASC, 2007; Hobfoll et al., 2007). Please [visit the TENTS](#) Web site for a full report on the systematic review.

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Guidelines

Best-practice guidelines of multi-agency (immediate) post-disaster psychosocial response with various levels of intervention, were developed through achieving a consensus of expert opinion, guided by the evidence available, using a three-round Delphi process (Bisson et al., 2010). Shortly, in a web-based manner experts rated the importance of almost 100 statements, generated from existing evidence, for inclusion in the guidelines on a 9-point Likert scale. Experts reassessed their original scores in a second round, and rated statements where consensus for inclusion had almost been achieved in a third round. The final guidelines comprise six sections e.g., planning, preparation and management; and general and specific components to be included during four specific phases of the response. Please [visit the TENTS](#) Web site for the full guidelines.

Dissemination

Following a needs analysis, dissemination occurred through local delivery of teaching packages and other methods of learning and was aimed at various levels of providers and not solely at mental health professionals. Associated partners visited countries they liaised with during the mapping process and met local experts again to inform them about how best to respond in an evidence-based manner to disasters. To this end, a half-day teaching workshop was embedded in the visits to local areas in close cooperation with local experts. Furthermore, brochures and flyers in different EU languages were disseminated to the local experts and published on the [TENTS Web site](#) to inform anyone interested and help areas to develop appropriate services for trauma victims.

Networks

In order to achieve the general goals of TENTS, i.e. to create and sustain expertise in the field of post-disaster traumatology across Europe, local networks were built throughout Europe. Several local trauma networks have become linked to TENTS and an extensive list of network members has been built. In order to impart a spirit of collaborative working to help organise and strengthen the mental health services of provincial and district health authorities and to ensure sustainable action and improvement in the future, at least one local expert from each country was invited to the final TENTS meeting in Brussels. At this meeting, experts from over 25 European countries were present.

Conclusion

Through TENTS we have been able to start building a Europe-wide network of expertise on psychosocial interventions for victims of natural and other disasters.

Furthermore, TENTS has made it possible for local experts from areas such as Eastern and Southern Europe, to receive information on how to best respond to disasters in a more evidence-based manner and to consult other experts from the TENTS network should a disaster occur in the future. Sustainable action and improvement in the future is further ensured by EU funding of a new project. The TENTS-Training and Practice project (TENTS-TP) will expand and develop the network and connect to other important European initiatives in the field of psychosocial care after trauma. TENTS-TP aims to implement evidence-based interventions to prevent trauma survivors from developing posttraumatic disorders and interventions to promote (early) recovery in particular through the development of training and practice guidelines for professionals based on the previous TENTS evidence based model of care.

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Book Corner

John Raftery, PhD

Adelaide South Australia

Review of: Valent, P. (2009). *In Two Minds: Tales of a Psychotherapist*. Sydney: University of New South Whales Press.

In Two Minds, a memoir by Paul Valent reflecting on his long career as a psychotherapist who specialised working with traumatised patients, is totally accessible and engrossing. Openness and honesty are hallmarks of this accessibility. His work, which is personally revealing as well as theoretically and professionally rich, is reminiscent of Patrick Casement's (2006) biographical account of 35 years of analytical therapy in Britain, (*Learning from Life*). Valent's book is a gripping read, with each chapter focusing on a different client, professional dilemma, theoretical issue, or significant phase in his life. His use of literary devices allows the reader to take an intimate and dramatic tour through his own and others' lives.

Paul Valent worked as a psychiatrist in Melbourne Victoria from 1972 until he retired in 2002. In retrospect, Melbourne was a good site to develop a professional life, as Victoria has always been at the forefront of ideas and practice in mental health in Australia. By the 1970s significant reforms had been achieved in public mental health services, and from 1972 Medicare provided unlimited access to private psychiatric treatment. Valent had some prominent forefathers in Melbourne, such as Paul Dane. Dane had written in 1925 that treatment of the trauma-related psychiatric casualty from World War One needed 'to restore to consciousness the lost memory', rather than repress it with physical treatments. The integration of traumatic memory into conscious life was the hallmarks of Paul Valent's practice.

At an international level, Valent's timing for becoming a psychotherapist and traumatologist was also fortuitous. The peak of his career coincided with the emergence of trauma as a central factor in the aetiology and treatment of psychological pathology. Recognition of the impact of traumatizing events on mental health had been successfully repressed within the psychiatric profession after World War One. The ideas of William Rivers, Pierre Janet and Charles Myers, to name a few, had been deleted from the mainstream psychiatric narrative. Both the theoretical and therapeutic lessons of trauma as a toxic event were relearned during Valent's professional life, and he not only participated in, but also contributed to, this era. In seeking to make sense of his patients' troubles, Valent initially revisited the ideas of Sigmund Freud, but like others in the field of traumatology, found

them wanting. To understand, for example, self-harm or the hearing of inner voices, the therapist needed to focus directly on the traumatic events, rather than unresolved inner conflict. Within this historical context, Valent immersed himself in the burgeoning research and writing on traumatic stress, particularly of the 1980s and 1990s, and translated it into his practice.

In *In Two Minds*, two parallel narratives merge, that of the author, the central narrator, and those of his patients and colleagues whom he encountered. This is not unlike the merging of the parallel narratives of Roseanne and Dr Grene in Sebastian Barry's *The Secret Scripture*. In Barry's award winning work, Dr Grene remained somewhat removed, but Valent's narrative is very raw and intensively reflective.

Valent is intensely honest in the account of his psychoanalysis and his own life story. In several chapters he recounts facets of his personal history, focusing in particular on the life-long effects of his childhood in Nazi occupied Hungary...

Throughout *In Two Minds*, the reader is invited into the intimacy of the consulting room, a death bed in a hospital, an intense session of a group of child survivors of the Holocaust, the fire-front in a major bushfire, and more importantly, into Valent's own mind as he struggles to make sense of the inner world of others. In his individual therapy sessions, and in the other clinical settings such as liaison psychiatry, Paul Valent held out against a purely medico-biological view of illness. In his pursuit of a bio-psycho-social approach he was not always accepted, and even openly criticized, by his peers. Throughout his narrative, the words of one of his early teachers, that drugs and physical treatments repress the 'brain's circuits and emotions', informed his every interaction. Valent's central theme recurs: you need to talk and create a narrative, not repress your experience. Indicative of this was his remark to his colleagues when they were on

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their way to assist communities ravaged by bushfires in 1983. He observed that the ambulances and medical teams were weighed down with equipment, while their only equipment was their capacity to listen and make sense of traumatic experience. His invitation for patients to create a narrative most often began with an invitation: 'of all the things that worry you, what worries you the most?'

Valent is intensely honest in the account of his psychoanalysis and his own life story. In several chapters he recounts facets of his personal history, focusing in particular on the life-long effects of his childhood in Nazi-occupied Hungary. Little in his life is left unexamined. This scrutiny of his own experience and thoughts underpins Valent's lifetime commitment

to the traumatized patient. Here the merging of personal and professional histories is most poignant. Valent's humanity and sensitivity shine through every chapter, as does his frustration at the ignorance of some medical colleagues, and his anger at the cruelty and evil of the perpetrators of abuse.

Unlike some of Valent's earlier work, *In Two Minds* is not a formal academic treatise. However, its value is otherwise: it provides a unique historical record of an important era of development in knowledge and understanding of the impact of traumatic events. For those who are involved in or seek to understand complex trauma treatment, *In Two Minds* will prove a rich source of knowledge and inspiration.



Visit the ISTSS Amazon Store

The [ISTSS Amazon Store](#) (also accessible from the ISTSS homepage) features trauma-related books for professionals and the public. The store allows ISTSS members and others to locate useful resources, while helping to support ISTSS.

ISTSS earns a referral fee of 4% to 10% for items purchased through the site. Any Amazon purchase that originates through our store helps to support ISTSS. To find other Amazon items, just click the "Powered by Amazon" button in the upper left corner of the page and continue shopping.

Titles featured in this issue are available at the ISTSS Amazon Store, including:

[*In Two Minds: Tales of a Psychotherapist*](#)
[*The Sweet Hereafter*](#)

Please send suggestions to Nancy Kassam-Adams at nlkaphd@mail.med.upenn.edu.



REMINDER - REGISTER NOW! ISTSS Psychotraumatology Meeting

This symposium is your opportunity to join leaders in the field for an ISTSS meeting in conjunction with the 15th Zürcher Psychotraumatologie-Tagung in Zurich, Switzerland on April 17, 2010!

This one-day symposium's plenary sessions and workshops will provide cutting-edge information for psychologists, psychotherapists, psychiatrists, social workers, researchers, journalists, healthcare managers, lawyers and others involved in working with the aftermath of trauma. [Register NOW Online](#). Members of ISTSS and members of ISTSS affiliate societies are eligible for reduced registration fees!

The Canadian Psychological Association's Traumatic Stress Section (CPA TSS)

Anne Dietrich, PhD, Past Chair

I observed the 2010 Winter Olympic Games over the past 2 weeks here in Vancouver and I have witnessed a transformation of the city as we have welcomed the world to compete in the games. I am struck at the sense of unity and cooperation that pervades the city, in spite of the diversity of the countries participating and observing. Individuals and groups from a wide variety of cultures have come together to share in the trials and accomplishments of the world's top young athletes. Other than a small number of people who engaged in some mischief earlier on in the games with ensuing conflict with the police, crime statistics for the city are actually down. It is amazing to watch as diverse groups who share a similar focus and goals join forces and create a united sense of community that is greater than the sum of its parts.

The Traumatic Stress section (TSS) of the Canadian Psychological Association (CPA) is very pleased with our new affiliate status with the ISTSS. The CPA TSS originated as a Special Interest Group in 2001 under the auspices of Dr. David Hart. The SIG obtained section status from the CPA Board in 2002, with the title of *Disaster and Trauma Section*. This was changed to the more encompassing *Traumatic Stress Section* in 2007.

The aims of the CPA TSS include the promotion of evidence-based mental health assessment and treatment of traumatic stress, educating the public about treatment and research, and advocacy. Advocacy efforts are aimed at research funding, advocacy for populations vulnerable to traumatic stress (e.g., disabled, First Nations, refugees, new immigrants) and advocacy for more inclusive coverage of effective treatment for traumatic stress.

To this end, the section's aims include encouraging public and private sector agency involvement in developing effective policies and strategies to address the effects of traumatic stress in Canada, informing public about the prevalence, economic effects and psychological science pertinent to traumatic stress, promoting discussion of trauma research and related issues through participation in programming at the annual convention, contributing section newsletters and electronic media; facilitating development of emergency planning in Canada via public education, promoting appropriate training for treatment, and establishing information exchanges with other associations involved in traumatic stress issues.

Membership is open to psychologists who are members of CPA and Associate Membership is open

to professionals of any discipline who are not members of CPA but who have a demonstrated interest and expertise in the area of Traumatic Stress.

The TSS has an informative Web site (www.cpa.ca/sections/traumaticstress/) and publishes a bi-annual newsletter, which is bilingual (English and French). We have had ISTSS members as guest speakers at the CPA Annual Convention in June, and plan on continuing with this practice. We have a yearly business meeting and reception at the CPA Annual Convention.

The Executive structure of the section includes the chair (Dr. Alain Brunet), past chair (Dr. Anne Dietrich), chair-elect (vacant), Secretary-Treasurer (Dr. Deniz Fikretoglu), and two student representatives (Nick Carleton from the University of Regina and Laura Armstrong from the University of Ottawa). Dr. Brunet's administrative assistant, Elena Saimon from McGill University, helps in the organization and functioning of the section's activities.



NEW! ISTSS Continuing Education (CE) Programs

ISTSS understands your needs as a professional in the traumatic stress field and now offers new ways to earn CE credit from your home or office. Earn CE's conveniently online without the cost and inconvenience of travel. Members enjoy reduced rates!

For Credit Offerings:

- [Journal CE](#) – Each issue of the *Journal for Traumatic Stress Studies* offers 3 CE credits. Credits can be purchased by month or with a discounted subscription.
- [Recorded Pre-Meeting Institute Sessions](#) from the 2009 Annual Meeting offered for 4 CE each.
- [Recorded Master Clinician Sessions](#) Several 2009 Annual Meeting sessions were and will be available for 1.5 hours of CE each.

Non-Credit Offering:

- [MP3 Downloadable Audio Recordings](#) of most sessions of the 2009 Annual Meeting with accompanying slides.

Choosing education sessions from ISTSS ensures you the most relevant and sensitive training from the best minds in the field, at a price that won't break your budget. Questions? Contact: emoy@istss.org.

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Upcoming Events

April 7-10, 2010

Association for Death Education and Counseling (ADEC)
32nd Annual Conference
Hyatt Regency Crown Center
Kansas City, Missouri, USA
www.adec.org/conf/index.cfm

April 8-10, 2010

European Society for Trauma and Dissociation International
Conference
Queens University Belfast, Northern Ireland
<http://www.estd.2010.org>

April 17, 2010

[ISTSS Psychotraumatology Meeting](#)
Zürich World Trade Center
Zürich, Switzerland

June 2-5, 2010

6th World Congress of Behavioral and Cognitive Therapies (WCBCT)
[Association for Behavioral and Cognitive Therapies](#)
Boston, Massachusetts, USA
[Boston University](#) and the (ABCT)

October 16-18, 2010

27th Annual ISSTD Conference
Pre-conference Workshops, October 14-15, 2010
Hilton Atlanta Hotel, Atlanta, GA
<http://www.isst-d.org/>

November 4-6, 2010

ISTSS 25th Annual Meeting
with Pre-Meeting Institutes Nov. 3
Le Centre Sheraton Montreal Hotel
Montreal, Quebec, Canada
www.istss.org

November 3-5, 2011

ISTSS 26th Annual Meeting
with Pre-Meeting Institutes Nov. 2
Baltimore Marriott Waterfront
Baltimore, Maryland, USA
www.istss.org

November 1-3, 2012

ISTSS 28th Annual Meeting
with Pre-Meeting Institutes Oct. 31
JW Marriott Los Angeles at L.A. LIVE
Los Angeles, California, USA